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ABSTRACT

A program was conducted to develop a reliable, uniform recording system to describe activities of consultation, mental health education and community organization for program description and assessment which can be used in management and planning. 25 of 47 functioning programs, including regional branches of three county programs, were studied. The report is divided into six parts: (1) background, (2) indirect services, (3) diversity among local programs in California, (4) program planning, (5) problems of reporting, (6) community mental health information model. Also included is an annotated bibliography. (Author/MC)

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INDIRECT SERVICES

The Bridge Between Mental Illness And Mental Health

Pauline E. Parker
Barry D. Terranova

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ED036811

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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INDIRECT SERVICES

The Bridge Between Mental Illness and Mental Health

Including Programming and Reporting Models

STATE OF CALIFORNIA
DEPARTMENT OF MENTAL HYGIENE
DIVISION OF LOCAL PROGRAMS

June, 1969

STATE OF CALIFORNIA—HUMAN RELATIONS AGENCY
RONALD REAGAN, Governor

DEPARTMENT OF MENTAL HYGIENE
744 P STREET
SACRAMENTO 95814

August 15, 1969

James V. Lowry, M.D.
Director
Department of Mental Hygiene
744 P Street
Sacramento, California 95814

Dear Dr. Lowry:

At the behest of the Conference of Local Mental Health Directors, the Department made application and received in 1964 a grant from the National Institute of Mental Health to develop criteria and reporting instruments for use in describing, managing and assessing indirect mental health services within the local mental health programs. The attached report is a product of that grant.

Staffing of the three-year project was delayed until June, 1966. This delay has proved fortuitous in that the report reflects significant philosophical, programming and management changes taking place in the mental health field within recent years. Emphasis within the report has been moved from the more traditional concepts of services to consideration for the informational needs of management.

We take pleasure in transmitting this report to you.

Sincerely yours,

William B. Beach, Jr., M.D.

William B. Beach, Jr., M.D.
Deputy Director, Department of Mental Hygiene
Chief, Division of Local Programs

ACKNOWLEDGMENTS

Without the cooperation of participant program administrators, accomplishment of our mission would have been impossible. Persons caught up in projects such as the one culminating in this report are painfully dependent upon the goodwill and patience of busy people in sharing their day-to-day world and all its minutiae with them. It was our good fortune to fall into the hands of generous, interested and knowledgeable professionals who spent many hours guiding us through the intricate maze of the mental health services.

Special acknowledgment must go to staffs of three programs: Berkeley City Mental Health Services, San Mateo County and Butte County. Members of the Berkeley program assumed the onerous task of initiating us in the language, processes and delivery of mental health services. The interest and support of the consultation and education staff sustained us through months of confusion and near despair.

The consultation services of the San Mateo program served as our home-away-from-home while we studied the many facets of that program. The consultation staff devoted long hours exploring with us the definitional problems and pitfalls in quantifying activities of indirect services.

The innovative program of Butte County opened our eyes to new and exciting ways of weaving mental health services into the social fabric of a community. The functions of this program and the philosophy of its staff gave substance to our faith in the validity of the community mental health model.

We are indebted to William B. Beach, Jr., M.D., Deputy Director of the Division of Local Programs for the total freedom he, as principal investigator, allowed us in the conduct of the study. Miron W. Neal, M.D., Deputy Director, Division of Research and Training, as co-investigator during the first half of the project, now receives our gratitude for his refusal to allow us the emotional security of becoming locked into a formal research design. His guidance in the exploratory period has led to, we believe, more meaningful results than was predictable in the beginning.

We owe Mrs. Guille Libresco, psychiatric social worker from the Yolo County Program, special thanks for her careful reading of the chapter on indirect services and her pertinent revisions in light of her expertise as a mental health consultant.

Were it not for Mrs. Carol Silkoff's valiant, capable and sustained stenographic efforts, this report would never have reached the printers.

This study is a synthesis of what we have read, seen, heard and experienced in terms of our objective. It is unlikely that anyone participating in our explorations will recognize his particular contribution. We, of course, take full responsibility for the contents of the following chapters.

The entire project was made possible by PHS Research Grant R01 MH15034.

Pauline E. Parker and Barry D. Terranova
California State Department of Mental Hygiene
August, 1969

The opinions or conclusions stated in this publication are those of the authors and are not to be construed as official or as necessarily reflecting the policy of the Department of Mental Hygiene.

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I.

BACKGROUND

The uniqueness of the community mental health philosophy lies not so much in the treatment of the patient close to home as in the union of mental health resources with those of the rest of the community. The community mental health concept deals not "with isolated disease processes but with vicious circles of human misery and ineffectiveness, with patterns of self-defeating behavior that are hard to break because they are imbedded in the very texture of people's lives"(1). Treatment services within this philosophy are but one facet of the mental health program. The community itself becomes a focus of program concern. Not only is the mental health professional responsible for patients within his own system, he functions as a catalyst within the community, employing his skills and knowledge to draw community resources together, to improve the social contexts in which troubled people are involved. The established means for moving beyond the mental health facility and therapy services into the community comes through the services of consultation, education and community organization.

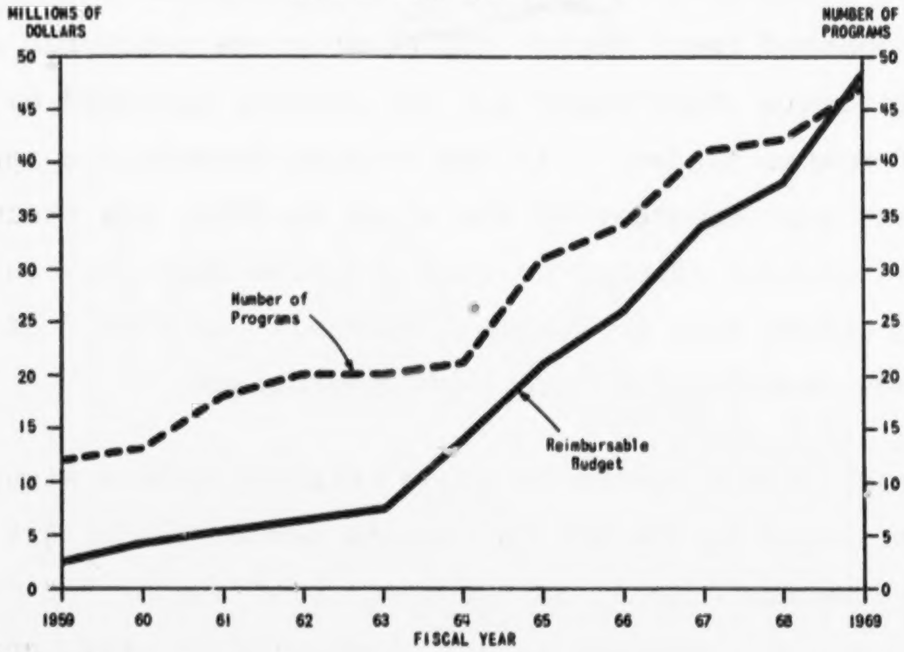
This segment of the mental health program which makes the mental health movement truly a part of the community is in jeopardy. Program decision from the legislative level down through those at the practitioner level continue to reinforce the traditional limited psychiatric treatment approach. A factor contributing to this state of affairs may well be the lack of information about community activities placed alongside patient data to make indirect services "visible" to decision makers. Significant data focusing upon these services might well serve to force policy decision makers at all levels to address themselves seriously to this portion of the mental health program.

Services to the mentally disordered and emotionally ill were revolutionized in California by the Short-Doyle Act of 1957, which established a funding mechanism for assisting communities in the creation of their own local mental health services. The number of local mental health programs has increased steadily. Starting with seven programs the first fiscal year, the number has grown in the past decade to 47 -- including two city programs within, but separate from, the county programs. Rapid growth in number of programs has been accompanied by a precipitous increase in monies allocated to mental health services. In fiscal year 1958-59, the reimbursable Short-Doyle budget was just over $300,000. In fiscal year 1968-69 it is expected to go over $48 million. The growth spurred by the shift from a 50-50 state-local sharing formula to a 75-25 ratio in 1963 is clearly evident in Figure 1 both in number of programs and reimbursable budgets.

By 1968, only 13 out of the 58 counties in California did not have Short-Doyle programs. These 13 counties encompass less than 10% of the state population. Although recent legislation stipulates that only counties with populations of 100,000 or more must participate in Short-Doyle, most rural counties are expected to enter the system in 1969-70. What course small counties with Short-Doyle programs will pursue after a year or more experience with the 90-10 sharing ratio after July 1, 1969 remains to be seen.

As the portion of the tax dollar devoted to mental health increases, demand for accountability also increases. For those programs having a sizable investment in community services, the need to account for these activities at the local and state level has been long standing. In 1961, a subcommittee of the Record and Statistics Committee was appointed by the California Conference of Mental Health Directors and was charged with the responsibility of developing an "indirect services reporting and analysis system". After two years of deliberation, it was concluded

Figure 1 REIMBURSABLE BUDGET FOR APPROVED SHORT-DOYLE PROGRAMS AND THE NUMBER OF APPROVED PROGRAMS
FISCAL YEARS 1958-59 through 1968-69



SOURCE: California Department of Mental Hygiene
Division of Local Programs

that the committee approach was inappropriate to fill this charge, the major problem being inability to reach agreement on basic criteria necessary for establishing the system.

At this point, the Conference of Local Mental Health Directors requested that the California State Department of Mental Hygiene apply for a federal grant to fund a research project to attack the problem. The Department agreed to the request and in November, 1964, a grant was approved by the National Advisory Mental Health Council. The grant was funded for a three-year period. During the time between approval and implementation of the project, several changes in personnel occurred so that it was not until June 1, 1966, that active study was undertaken. The National Institute of Mental Health, recognizing the personnel problems, extended the termination date of the project to May 31, 1969, thus permitting a full three years for the research to be carried out.

Purpose and Scope

The specific aim of the project, as stated in the grant application, is the development of a reliable, uniform recording system to describe activities of consultation, mental health education and community organization for purposes of program description and assessment which can be used in management and planning. The original statement, developed in 1964, encompassed local mental health programs receiving state subsidy under the California Short-Doyle Act and clinics operated by the Department of Mental Hygiene. In the interim between the application for the project and the start of the study in 1966, the status of state-operated clinics changed to such a degree that they and the Short-Doyle programs were no longer comparable entities. Of necessity, the project was restricted to Short-Doyle programs.

The state mental health system is again entering into a significant change brought about by the new California Mental Health Act effective July 1, 1969. Designed to alter the commitment system for the mentally ill, this legislation provides strong protection of civil and legal rights of mental patients and fosters greater integration of state hospitals and local programs. Further, it mandates the development of annual and five-year plans at the state and county levels and stipulates that evaluation will take place.

The mental health system evolving from interpretations of the recent legislation can only be surmised at this point. Treatment services of programs funded under the original Short-Doyle Act can be examined through analyses of patient data, but activities outside the treatment realm not directly involving patients are not adequately quantified and have been accorded little consideration in the trends of growth and significance of the community mental health movement in California.

Methodology and Design

Of the 47 programs functioning during the project, 25 operations were studied including regional branches of three county programs. Sites were selected on the basis of variations in geographical, urban and rural locations, size of operations, philosophy of leadership as reflected in service patterns and interest of staff in the formulation of a reporting system. Programs ranged in size from one with a part-time staff of two supported by a one-year reimbursable budget of $17,000 to one with a staff of over 500 supported by a reimbursable budget of approximately $20 million. The programs range in complexity from those provided within a small outpatient clinic in a rural area operating a few days a week to those which cover the full spectrum of mental health services including complex hospital operations in a huge metropolitan area. The indirect services in these communities range from token services rendered by treatment staff to comprehensive programs having formal hierarchies of supervision manned by highly trained specialists in the indirect service field.

The field work for this study included the techniques of observation and interview. Staff and managers were observed in their work settings including formal staff meetings. Both structured and unstructured interviews were held with program staff at all levels. Interviews were also conducted with recipients of program services and other community agents. The authors were also participant observers in meetings at the state level and in subcommittees of the Conference of Local Mental Health Directors.

Experience during the first year led to the conviction that common denominators which would receive consensus, be discretely defined and provide valid, reliable data could not yet be developed along the lines desired and anticipated by practitioners and managers of county programs. Their ideal of a reporting system appeared to be one which could record specific methods of consultation and education as applied by the mental health professional to specific problems and the impact of these processes upon the mental health of their clientele. Where the term "process level" is used within this report it implies the orientation reflected above which is concerned with the manner in which an activity is carried out rather than a focus upon what the activity is intended to accomplish.

The mental health professional's concern is rightfully focused upon the development, application and evaluation of techniques employed in carrying out his responsibilities as educator and consultant. However, even if a reporting system were devised to reflect effective processes and techniques, the utility of such information for purposes of management and accountability at the county and state level is questionable.

Having extricated the study from the process level, efforts were directed toward the data requirements for planning, implementing and evaluating the community-oriented portion of the program at the management level. This approach is in keeping with the legislative mandate now laid upon the mental health system to develop formal planning and evaluation statements. The rationale and models presented in the body of this report are developed around tools which may be useful for meeting the mandate. To facilitate communication, the traditional terminology of indirect services has been employed within most of this report. However, concepts developed in the final chapter require the reader to adjust to new terminology and definitions.

The reader expecting guidelines for quantifying activities in terms of impact of specific practices upon the client will be disappointed with this report. The reader seeking a means for incorporating staff activities into a cohesive, goal-oriented program may find the contents of this report useful, and we will have approached the charge placed upon us.

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1. Smith, Brewster M.: The Revolution in Mental Health Care -- A "Bold New Approach"?, Transaction, April, 1968, p.21

II.

INDIRECT SERVICES

Indirect services have much the position in the mental health program as the young upstart brought into an establishment to fulfill a need created by change in the establishment. The old timers do not understand his language, have vague comprehension of his duties and serious reservations as to the worthiness of his efforts. This chapter is devoted to the upstart's position in the mental health program, both to clarify what is to be dealt with throughout the rest of this report and -- of equal importance -- to clarify and ground these services so soundly that the old timers and the uninitiated will understand them as legitimate, significant components of the community mental health movement.

Philosophy and Functions

A major postulate of the community mental health movement is that a relationship exists between the mental health of individuals and their environment. A somewhat limited, treatment-oriented acknowledgment of this concept is the proposition that the best interests of the mentally disordered person are served through continuity of care close to home with as limited residential treatment as is essential to his welfare. Acceptance of this proposition has brought the psychiatric patient out of hiding and the psychiatric and para-psychiatric professional out of isolation.

Recognition of environmental factors and their influence upon the lives of the citizenry leads the mental health professional further into the community to function as educator, consultant and agent of social change for the control and prevention of mental illness. The community mental health movement thus affords a positive rationale for prevention as well as treatment services.

The basic tenets of the newer philosophy which set the perspective for community-oriented mental health services have been crystallized by Baker and Shulberg(1) into five conceptual categories covering the major aspects of the ideology.

1. A Population Focus: The view that the mental health specialist should be responsible not only for individual patients with whom he has contracted for treatment but for the entire population of both identified and unidentified potentially sick members in the community.

2. Primary Prevention: The concept of lowering the rate of new cases of mental disorder in a population by counteracting harmful forces before they have had a chance to produce illness.

3. Social Treatment Goals: The belief that the primary goal of treatment is not to reconstruct the mental patient's personality but rather to help him achieve social adjustment in an ordinary life situation as soon as possible.

4. Comprehensive Continuity of Care: The view that there should be a continuity of professional responsibility as the patient moves from one program to another in an integrated network of caregiving services.

5. Total Community Involvement: The belief that the mental health specialist is only one member of a group of community agents caring for the mentally ill and that he can extend his effectiveness by working with and through other people.

Professional assumption of responsibilities for a broader population, primary prevention and total community involvement has brought about the development of services termed "indirect".* Mental health education, consultation and community organization have been generally representative activities coming under this category. (Community organization activities have an important function within the indirect services and have the potential for becoming increasingly important as the recent legislative demands for coordination of community resources in behalf of the psychiatric patient are implemented. Activities in this area, however, have not been separated out, either at the federal or local level, as a service.) The development of these indirect services is a major concern of this report.

Total community involvement in meeting the mental health challenge is the far off vision of those seriously involved in indirect services. Reality for them, however, lies in pooling their specialized expertise with the specialized expertise of other caregiving agents within the existing social network to incorporate awareness, concern and consideration of the mental health factors intermeshed in the social milieu.

At the operational level, the ensuing premises support and give direction to indirect service activities within the county programs and justify their inclusion within the list of mental health services reimbursable by the state.

---

* Dissatisfaction with the term "indirect services" is prevalent among mental health educators, consultants and others for its connotation implying secondary importance to direct services and for its inadequacy in representing the activities coming under this category. However, it is a generally accepted term and it will be employed within these first chapters.

1. The number of fully-credentialled mental health professionals will be insufficient to meet the needs for direct services for years to come. (Even with sufficient services there is question as to the efficacy of direct services for all.)

2. A large proportion of socially dysfunctional persons have mental health problems and become visible in other social agencies, such as schools, welfare, courts, probation, family services and through other social agents including physicians and clergy.

3. Increasing numbers of psychiatric patients, supported by psychotropic drugs and crisis-oriented services, are living within the community, requiring maintenance and understanding from family members, employers, social agents and the total community.

4. Members of the social support systems, through services provided by mental health professionals, can extend their already considerable skills to include techniques which may forestall and/or handle many of the mental health problems of their clients, thus reserving limited treatment services for those cases so acute as to require intensive professional care.

5. Mental health professionals can be influential in developing and coordinating social resources to meet the needs of the community's socially dysfunctional members, and can promote social change conducive to better mental health for populations caught up in the social subsystems.

6. Mental health education directed to all segments of the population can further the state of well-being of all members of the community.

7. The combination of all the community mental health services working with the rest of the social network can assist the community in creating an environment conducive to improved mental health of its citizenry.

Smith(2) states in his recent article that "buildings are not the strategic ingredient of a community mental health center. The key ingredient is services -- and services mean professional people. . . There are not enough to go around and there won't be in the foreseeable future." He suggests as a solution the use of non-professionals to multiply the effectiveness of professional resources.

The use of mental health consultants and educators can also multiply the effectiveness of professional resources. Mental health consultants, with their skills in process, assist personnel in other agencies and professions to focus on their own expertise, special advantages and knowledge in solving problems in their own fields. Aiding caregivers to recognize and respond appropriately to the mental health aspects of their clients' problems not only can help to maintain demand on the mental health system at a manageable level but also can have a fanning-out influence upon those who come in contact with an agency whose staff receive mental health consultation services. Programs of mental health education to groups and to the public can have a similar spanning effect upon attitudes and knowledge. The diagram in Figure 2, using Caplan's consultation categories(3), illustrates the "shadow" populations potentially affected by the different types of consultation, education and community organization services.

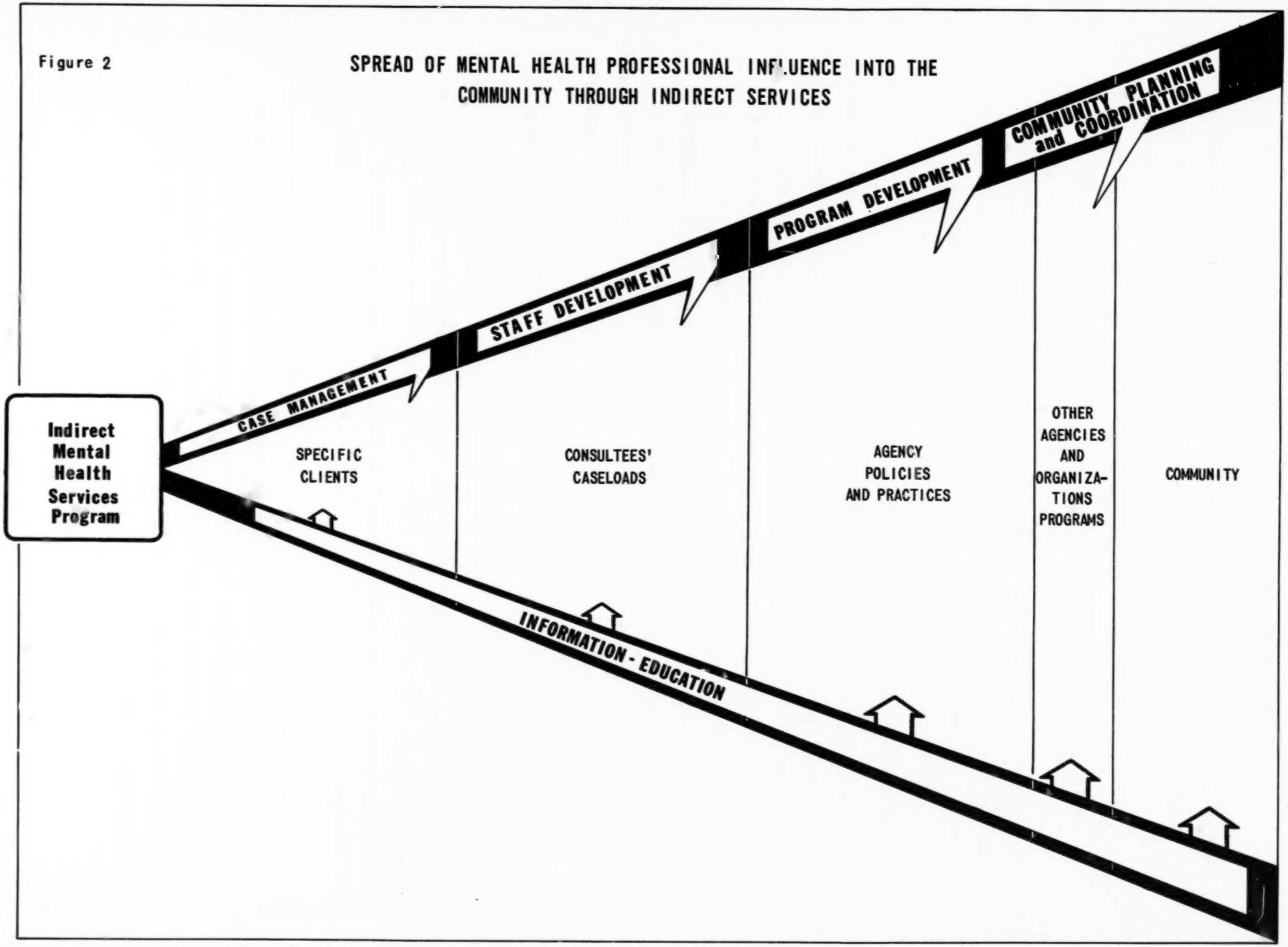
A social worker may request consultation in behalf of a depressed mother in the worker's caseload. Together in client-oriented consultation, the worker and consultant may serve to maintain the mother adequately within her own home through provision of some kind of emotional support or environmental change; or they may draw upon other community resources, including the mental health facility, to resolve the problem. The caseworker's experiences in working through this client's problems can have application to similar situations within her caseload.

A teacher having difficulty in maintaining discipline within her classroom may explore the problem with the mental health consultant. In doing so, she may gain a better understanding of her interactions with students and develop new techniques appropriate to the classroom. Consultee-oriented consultation of this type may have positive influence upon 150 or more students passing through her classroom each day -- and so it goes as the level at which consultation takes place moves upward.

The degree of impact services will have is a function of many variables. The competence of the consultant or educator, the capabilities of the consultees or students, the responsiveness of consultee-organizations, the receptivity of the community to social change are but a few of the variables involved. Change, which is the essence of consultation and education services, is usually a slow process and results may be hidden within the complexities of the systems involved.

Figure 2

SPREAD OF MENTAL HEALTH PROFESSIONAL INFLUENCE INTO THE COMMUNITY THROUGH INDIRECT SERVICES


Indirect Mental Health Services Program
CASE MANAGEMENT
STAFF DEVELOPMENT
PROGRAM DEVELOPMENT
COMMUNITY PLANNING and COORDINATION
SPECIFIC CLIENTS
CONSULTEES' CASELOADS
AGENCY POLICIES AND PRACTICES
OTHER AGENCIES AND ORGANIZATIONS PROGRAMS
COMMUNITY
INFORMATION - EDUCATION

Participation in the development and coordination of community resources to meet the varied needs of socially dysfunctional members is also an influential use of mental health personnel. A well-functioning social network which relieves social and economic stress may lessen the risk of emotional malfunction which necessitates an individual's entry into the mental health system. Until more is known about the causes of mental illness, efforts of prevention and control at the environmental level come a step closer to mental health than the prevention model based upon early case finding and intervention through treatment.

Development of Consultative Relationship

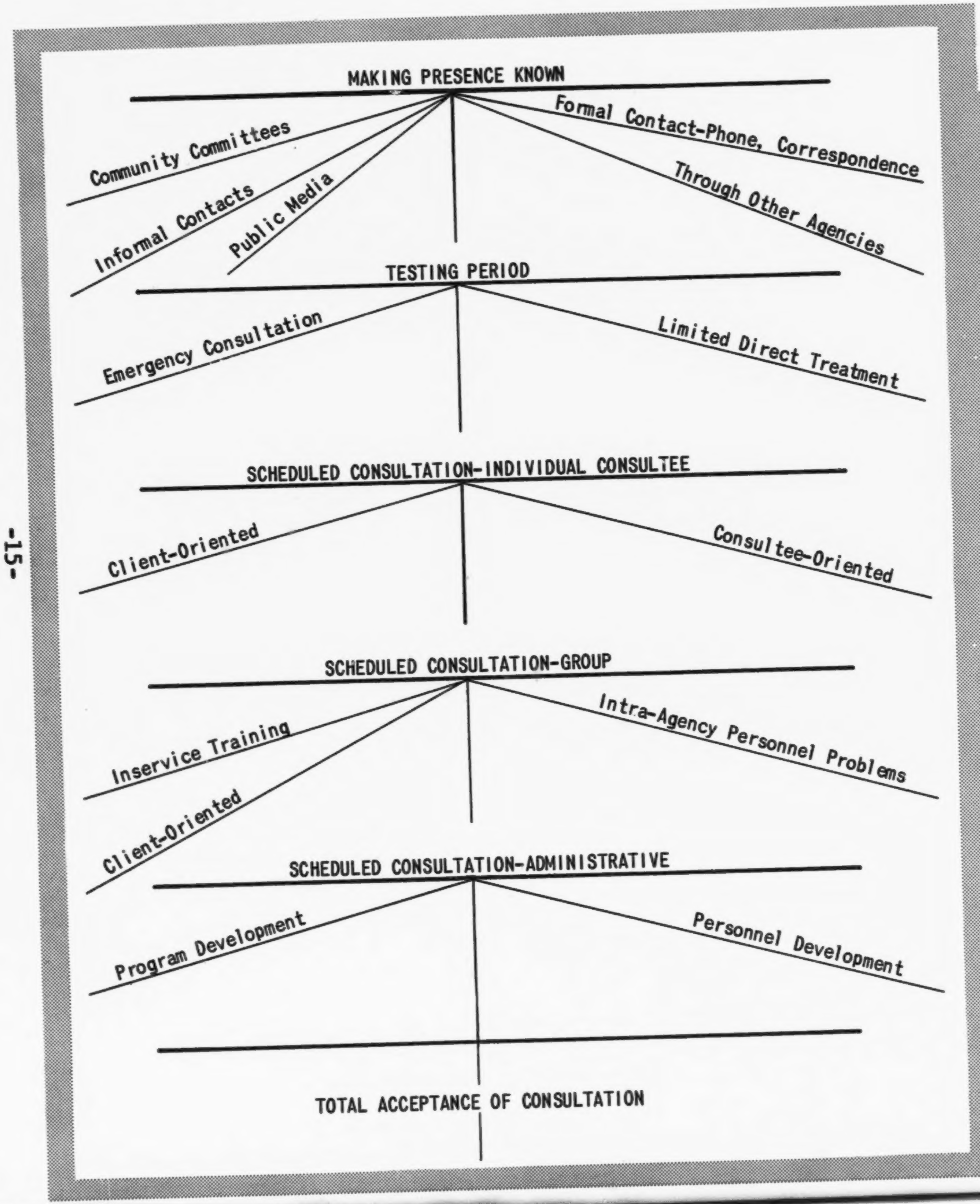
Most communities have been conditioned to accept direct treatment services. People are accustomed to the role of patient within a medical system and anticipate similar protocol within the psychiatric clinic setting. Mental health education is more readily accepted as a legitimate service of the mental health system than are consultation services. Personnel of social agencies and other professionals frequently are not prepared to accept or employ consultation services in combination, or in lieu of direct services for their clients. The expectations which many social agents have of mental health services can result in resistance to or rejection of consultation relationships. The appropriate expectations and use of consultation must be communicated to social agents in order to stimulate a demand for this service.

Some general developmental steps are required in bringing a consultation relationship between a mental health consultant and an agency to maturity. The theoretical diagram in Figure 3 defines the steps involved in the process.

The developmental stages are based upon the assumption that consultation services are new to the community. Under circumstances in which social agents are knowledgeable about the use of consultation, the first two steps of the process may be passed through quickly. For example, in some instances, group consultation may develop before consultees ask for individual consultation.

Figure 3

STEPS IN THE MATURATION OF A CONSULTATIVE RELATIONSHIP BETWEEN A MENTAL HEALTH SERVICE AND A COMMUNITY AGENCY
(THEORETICAL)


MAKING PRESENCE KNOWN
Community Committees
Informal Contacts
Public Media
Formal Contact-Phone, Correspondence
Through Other Agencies
TESTING PERIOD
Emergency Consultation
Limited Direct Treatment
SCHEDULED CONSULTATION-INDIVIDUAL CONSULTEE
Client-Oriented
Consultee-Oriented
SCHEDULED CONSULTATION-GROUP
Inservice Training
Client-Oriented
Intra-Agency Personnel Problems
SCHEDULED CONSULTATION-ADMINISTRATIVE
Program Development
Personnel Development
TOTAL ACCEPTANCE OF CONSULTATION

Objectives at Each Step

To develop relationship conducive to consultation services.

To prove the value of available services and reduce resistance and hesitancy about use of consultation.

To present techniques for dealing with mental health aspects of cases. To aid consultee in coping with personal reactions to cases (theme interference).

To present techniques and provide insight into mental health problems of more general nature. To work through personnel relationships.

To aid in the development of programs which have positive mental health aspects for the agency clients. To aid administrators in providing system in which personnel function at best.

Agency incorporates mental health considerations into its own structure, using mental health consultant appropriately and efficiently within and in interaction with other agencies and the community.

It is essential that those concerned with the fiscal and administrative management of an indirect services program be aware of the time necessary to initiate and maintain relationships which allow for successful delivery of these services. Time-consuming meetings, crisis intervention and other kinds of contacts may be necessary to achieve entry into a consultation relationship. Once achieved, the relationship has possibilities for a broad level of effective service.

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3. Caplan, Gerald: Principles of Preventive Psychiatry, Basic Books, Incorporated, New York, 1964, Chapter VII

III.

DIVERSITY AMONG LOCAL PROGRAMS IN CALIFORNIA

A key feature of Short-Doyle legislation is its provision for local administration and control of community mental health programs. This factor allows for wide diversity in the patterns of services and in program operations. Given this independence, local leadership determines which services are made available and the manner in which they are delivered.

The first part of this chapter examines the variability between Short-Doyle programs in the areas of organization, service emphasis and administrative influence. The second section attempts to forecast some effects of the new Lanterman-Petris-Short legislation.

Local autonomy has been a major emphasis of the Short-Doyle legislation in the State of California. Under the original legislation, state funding of local programs has been based on the total monies designated for the mental health programs by the counties conditioned only by the total state appropriation for local mental health services. Short-Doyle legislation has required that at least two out of the original five services be established, one of which must be a treatment or diagnostic service. Other than that requirement, those establishing a program have been free to select the combination of services to be offered and the administrative format for the delivery of services.

Organization

Individual Short-Doyle programs are organized in a variety of ways. They may operate as part of the local Department of Health, be attached to a general hospital or exist as a department within the county organization. Position in the county organizational structure and within the health care system has considerable impact upon a program's policies and development. Negotiations to gain program support become less effective as the number of levels increase between Short-Doyle administration and the top power structure.

Organization for delivery of services is also varied. Some programs are highly centralized, with most or all services located and rendered at one general location. A less centralized approach is the establishment of outlying branches which provide limited or specialized services. The team approach in which staff members from several disciplines go out into the community is another method of providing services.

A noticeable trend in the larger counties is toward regionalization. With this form of organization, a county or service area is divided into smaller geographical units and a relatively comprehensive program is established within each unit. Effort is devoted to fitting these branch programs into the uniqueness of the particular communities in which they are located.

Service Emphasis

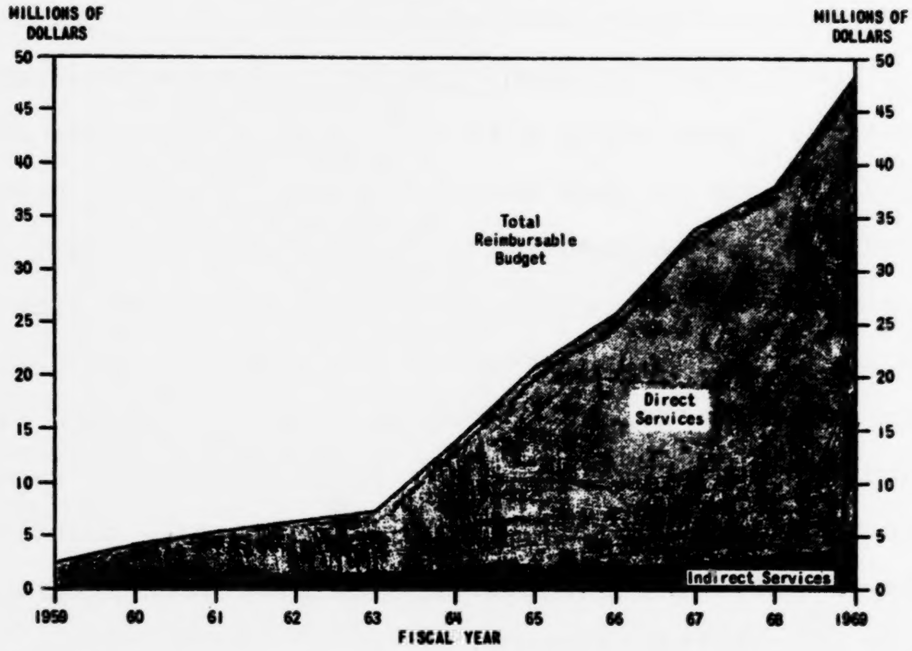
Programs seem to fall within a continuum from those functioning largely within the traditional patient-oriented pattern to those operating within a broader environmental pattern. Two terms, often used interchangeably, are employed discretely here to distinguish between the extremes of the continuum. The first term, community psychiatry, is used to describe treatment programs which have been established in the community to provide easier accessibility for persons seeking help. The second term, community mental health, is used to describe programs which focus upon the social context from which patients come as well as upon patients' therapeutic needs.

The major intent of the community psychiatry model is that of making treatment programs more accessible to the patient. The community is viewed as the supplier of patients, the provider of financial support and the receptor of released patients. The emphasis is upon "patient" and "treatment". Prevention of mental illness in this context is based upon a theory of progressive severity of the disorder. Early casefinding and treatment can intercede in the progression and, thus, prevent the patient from becoming increasingly dysfunctional. Information, consultation and education services are provided only upon demand and in an ad hoc manner.

At the other end of the program continuum is the community mental health model. The community is viewed as a network of social subsystems which nurture both mental illness and mental health. Program staff aim toward establishing a partnership with other caregiving agents to provide support for the mental health of persons within high risk populations. Professional, therapeutic support is available to alleviate crisis; however, consultation, education and community organization services are the hub of this type of program.

A few rural programs in California approach the community mental health pattern. A tendency exists for branch centers of larger county programs to approach the community mental health pattern, but the long-term trend, certainly in terms of fiscal outlay, is toward greater relative emphasis upon community psychiatry (Figure 4).

Figure 4 REIMBURSABLE BUDGETS FOR APPROVED SHORT-DOYLE PROGRAMS
BY TYPE OF SERVICE
FISCAL YEARS 1958-59 through 1968-69



*SOURCE: California Department of Mental Hygiene
Division of Local Programs*

Most programs now function somewhere between the community psychiatry pattern and the community mental health pattern. A few maintain formal structures which include both patterns by incorporating units of consultation and education into the organization separate from clinical services. The consultation and education unit is staffed with specialists in the techniques of consultation, education and community organization. The unit is typically responsible to the same position of authority as are the treatment units. This type of program differs from a community psychiatric program in that community services are recognized as a significant responsibility of the organization. It differs from a community mental health program as defined in that the patient remains isolated from the rest of the community social network as far as the therapist is concerned.

Administrative Influence

From our observations, program leadership towers in importance above all other variables conditioning the type and career of a program. The administrator's interpretation of the extent of psychiatric-mental health responsibility resting upon the program dictates the balance between community services and treatment services.

The administrator who views emotional disorder primarily as a medical phenomenon requiring highly skilled professionals in its treatment places his highest priority upon inpatient, day hospital and outpatient units. He staffs these units with therapists. Patients are his responsibility as long as they remain patients. Mental health consultants, educators and community organization specialists are last on his staffing priority scale. If these professionals are hired, he views their function as separate from the rest of the program. He looks at community relationships as the means of informing residents of his program's existence and availability as a psychiatric treatment resource and to gain the necessary public support for the program's maintenance within the community's political structure. The resultant program fits into the community psychiatry category.

The administrator who views emotional disorder as at least in part a social phenomenon requiring more than psychiatric treatment develops a less self-sufficient program. Consultation, education and community services are high on his priority scale. Treatment units are kept at a minimum. He staffs his program with professionals adept at relating to the community and capable of augmenting skills of other caregiving agents in the community. Disturbed persons, whenever possible, are maintained outside the treatment program through consultative support to social agents responsible for their welfare. When a client of a social agent is taken into a treatment unit, the social agent is kept informed of the patient's progress and is expected to maintain or resume responsibility upon his release. The administrator considers his program a part of the community's social network and shares responsibility in providing services which work toward the well-being of the total community. This type of program, in our terminology, is a community mental health program.

Social, economic and political conditions such as the rural or urban character of the county, the political attitudes and the degree of affluence of the county also influence the program. However, counties have been found comparable in these characteristics providing very different patterns of mental health services under administrators of different philosophical orientations.

Examples of Types of Programs

No program in California is a pure example of either community psychiatry or community mental health. All programs allocate some portion of their budget to indirect services. No program remains static through the years, although the rate of change may vary significantly within different counties. The examples given below are results of project observations in the past two years(1). Each one may have changed in service modalities since it was visited. For this reason, the programs are not identified.

Community Psychiatric Program. The program philosophy and resultant organization of Program A is built upon psychiatry as an established branch of medicine with the organization meeting the needs of the mentally ill who enter within its own walls. Inpatient services are provided under contract by the county general hospital with the mental health services furnishing the psychiatric treatment. A day care program provides occupational, group and recreational therapy and some rehabilitation services. The outpatient services include a walk-in clinic which serves as a major admitting unit for the total program, screens potential state hospital commitments and provides individual therapy for outpatients. All services are readily available to any patient with little administrative procedural restraint. Therapists assume little or no responsibility for communication with referral agents in regard to patients. Self referral is the program's preferred means of entry. Consultation services are provided to community agents by selected staff members but there is little involvement in mental health education services. The Director defines his role in community affairs as that of technical consultant on matters involving mental health. Within this advisory role he participates in significant community activities but can remain aloof from community conflict.

Program A is located in a county with a population of over 400,000. Agriculture is the most significant economic activity of the county with manufacturing closely related to agricultural production next in importance. The political climate is considered to be somewhat conservative. The mental health services are a separate department of the county located next to the county hospital.

Community Mental Health Program. Program B functions within the philosophy that mental health is the responsibility of the entire social network. Major emphasis is placed upon the integration of mental health services with other social services in the community. Staff members work to build relationships with other agencies and social agents in order to bring together supportive services which further the client's well-being. Patients, other than those in emergency status, are accepted only upon referral from professionals and agencies.

It is a program intent to see patient/clients whenever possible in the referral agent's office with the mental health professional working to make the treatment a part of the individual's social management plan. No fine line is drawn between consultation and treatment. Client/patient, consultant/therapist and caseworker integrate their efforts, which may include prescription of drugs, individual therapy, consultation between professionals, as well as inclusion of the family and other social agents, in doing what is deemed necessary to assist the client.

If a client is seen at the office of the mental health services, progress reports are provided the referral agent in written form (with permission from the patient) after each interview. The patient is returned to the referral source for appropriate long-term supportive services as soon as his condition warrants it. Consultation with the mental health professional frequently continues through this period of supportive care.

Inpatient services are provided within a medical-surgical ward at the county hospital with nursing and medical staff playing an important role in the provision of care. Patients are assigned to regular hospital wards and are in no way identified as psychiatric patients. Here, too, close communication and coordination are maintained with the referring agent in the expectation that the patient will be returned to the referring agent; thus, maintaining continuity of services after hospitalization. The mental health services staff do the psychiatric evaluation, consult with nurses serving the patient and are readily available to assist in the care of medical-surgical patients who may have psychiatric difficulties. Through every means the mental health professionals work to prevent persons from being "dumped" into the mental health services and cut off from the community.

This program is located in a county with a population of approximately 100,000 persons. The economic base is predominately agricultural production with lumbering and wood processing the leading manufacturing industries. Politically, the area is conservative. Short-Doyle was actively opposed by a substantial group of citizens before the county established mental health services.

Combined Psychiatric Mental Health Program. Program C patterns its services into two separate programs under one administrative head. Treatment services meet the criteria for a community psychiatric program while the consultation and education services function to create social change appropriate to the mental health of the community. The latter focuses particularly upon the network of social service agents concerned with high-risk populations. A field consultation team and the rehabilitation services bridge the two sectors of the total program. This is the one area in which the community services and the treatment services come together. Staff of the indirect services unit are well trained mental health consultants and educators. The program is modeled after Gerald Caplan's theories and processes. Staff are deeply involved in working with the school system, poverty programs, drug abuse and other current social problem areas as well as in providing mental health education to lay groups and the general public.

The mental health program is located in a sophisticated urban community which supports a wide range of social services. The program is under the overall direction of the Director of the City Department of Public

Health with active administration being carried on by a program chief. The large outpatient clinic is under the supervision of a clinic chief responsible to the program chief while indirect services are under the direct supervision of the program chief.

Impact of Recent Legislation

Implementation of recent legislation may move programs into greater conformity with each other. Procedures for persons involuntarily detained for evaluation and treatment are prescribed in detail within the Community Mental Health Services Law, effective July 1, 1969. How much influence the explicit structuring of services for the involuntary patient will have on the total pattern of services in a program is yet to be determined.

The pooling of state hospital and local program funds plus the funding priority system may restrict the prerogative of local programs more than expected within the legislative intent. The legislation addresses itself primarily to residential psychiatric treatment services with little specific regard for other community-based mental health services. Funding priorities give primacy to psychiatric treatment services for the involuntary patient. Second priority is given to the maintenance of Short-Doyle services established prior to July 1, 1969, and to providing for the care of county residents admitted to state hospitals prior to July 1, 1969 as mentally ill or inebriates. Funds remaining after these two priorities have been met may be used to expand existing programs, to provide services to voluntary patients entering state hospitals after July 1, 1969, or to establish new Short-Doyle programs in accordance with priorities determined by the county.

When this legislation takes effect, counties will have to pay 10% of the cost of state hospitalization to county residents receiving services from state hospitals.* This new fiscal responsibility is offset by the shift from 75% state reimbursement to 90% state reimbursement for mental health service costs.

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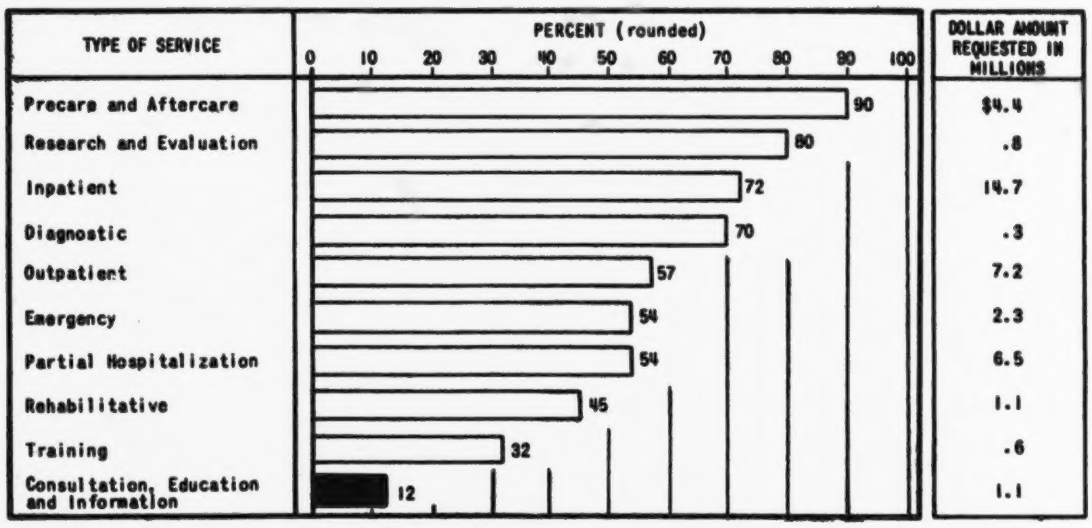
* The Community Mental Health Services Act does not apply to persons committed as mentally disordered sex offenders, narcotic drug addicts, habit-forming drug addicts, mentally abnormal sex offenders, mentally retarded persons, juvenile court wards and mentally disordered criminal offenders.

Characteristically, counties are meeting these legislative changes in diverse ways. The fate of community services in competition for program funds is uncertain. It is apparent from Figure 4 that fiscally, indirect services have not kept pace with other services over the years. Figure 5 reflects the dollar amounts requested for new or expanded programs by type of service for fiscal year 1969-70. The bar graphs show the percentage approved of the amount requested for each service. For example, of the $14.7 million requested for additional inpatient services, 71.5% was approved; of the $1.1 million requested for expanded consultation, education and information services, 12.1% was approved.

Figure 5 APPROVED SHORT-DOYLE-EXPANSION FUNDS AS A PERCENT OF THE AMOUNT REQUESTED BY TYPE OF SERVICE FISCAL YEAR 1969-70



SOURCE: Data developed by Bureau of Biostatistics and Bureau of Budget Analysis

The Department of Mental Hygiene and individual county mental health programs support and function, within legislative and regulatory limitations, to maintain local autonomy within the mental health system. The diversity in organization, administration and operations reflect this commitment to the principle of local determination. Individual programs are shaped in large part by the orientation of their leadership toward community involvement. This orientation is demonstrated to a large degree by the extent of the indirect services program provided. Recent legislation may have significant impact on the course of indirect services as well as on the pattern of direct treatment services.

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IV.

PROGRAM PLANNING

Diversity among programs is more a function of staff interest than of response to community needs. This is particularly true within the indirect services activities. Professional emphasis upon methodology of consultation and education has not provided principles for making the decisions required of administrators in programming these services. Decisions regarding kinds and emphasis of various services are made with insufficient consideration for their interrelatedness. Attitudinal variables play a significant role; expenditures affect demand and costs simultaneously; activities performed in one area have major effects in other areas.

These characteristics support the current intuitive approach to program development. Although this approach is easily defended, a program of indirect services should be based upon an understanding of the interplay between these services and the environment in which they are provided. This section places relevant variables into a framework helpful to program administrators in visualizing this interplay. The aim of this section is to provide ways of thinking about and analyzing recurring problems rather than to provide answers. The emphasis is two-fold: (1) a planning orientation and (2) an analytical approach.

Current State of the Art

The mental health professional is an individualist. He has acquired a body of knowledge in his own speciality, usually within an academic setting, which has provided him with a career orientation toward his world and toward his work. He has a long-term educational investment in himself, is achievement-oriented and desires both financial and emotional satisfaction from his work. He views the organization which employs him as more the base from which he carries out his professional responsibilities than as the source of his professional identity or as the object for his allegiance and status. His professional independence is of major concern to him.

As a specialist, the professional is engrossed in the refinement of processes involved in carrying out his duties and is likely to give little thought to the integration of his services with those of other staff in the development of long-range program plans. He is more likely to view planning at the management level as an invasion of his realm and a threat to his effectiveness as a practitioner.

Candidates for management positions are drawn from the specialist ranks(1). The placement of the psychiatric specialist in the position of the management generalist perpetuates the professionalism syndrome upward through the mental health hierarchy. The laissez-faire attitude toward program development held by the practitioner tends to linger with the psychiatrist-turned-administrator. Beyond the time devoted to survival of the organization, management demands necessitated by budget and fiscal requirements receive most of his administrative attention. The development of a program as it relates to measurable goals and program evaluation is often a paper activity required by budget mandate. Rarely does such planning filter down to influence daily activity, least of all within the indirect services.

The foregoing factors can result in a community mental health program operating far below its effective capacity. Fragmentation, which occurs when individuals substitute personal goals for organizational goals, leads to dilution of overall program effectiveness. Available resources are wasted if not developed to their full potential. Both de-emphasis of indirect services and preoccupation with the process involved in rendering them can lead to less than optimal utilization of staff resources.

Total program planning requires the recognition of major variables, an understanding of the changing nature of the operational environment and offers a means for dealing with this change. The following subsection deals with major areas influencing program development. An awareness of these factors is preliminary to the development of a planned program of community mental health services.

SITUATIONAL ANALYSIS
(Preparation for Planning)

The planning process begins with an attempt by the administrator to size up the critical or limiting factors to which his program must relate. He must consider the ecology of the total environment, including economic, political, cultural and educational factors. Changes resulting from the passage of time -- the natural consequences of things happening, growing, maturing, aging or being reinvigorated or renewed -- require forecasting to determine their impact on the program. An awareness of the forces interacting within and upon the community is critical not only to planning but to appropriate and timely adjustments in ongoing operations.

The Community

The concept of community mental health presented in this section holds that mental health programs can be more effective if oriented outward toward the community rather than inward toward specific services. This means that program development should begin with acquiring an awareness of the community. The aim here is to provide a logical basis for making decisions concerning services appropriate for particular communities during a selected planning period.

Social, economic, political and geographical characteristics tend to merge to form somewhat unique communities. These factors determine in varying degrees the definition of social problems within the community, the degree of responsibility the community is willing to assume in meeting its social needs and the mechanisms by which these needs are met. Each community mental health program manager must assess these factors to determine whether they represent limitations or opportunities for program implementation.

Sources of data which can help the administrator assess a given community may include the Federal Census Tract publications, records compiled by public departments such as county welfare, health, juvenile probation, state mental hospital facilities, police department, special surveys in large communities and direct staff feedback.

These sources should provide baseline data from which information for planning can be developed. In small communities the community mental health center's manager might be able to process the data into information with little or no manipulation. In the large urban areas a more complicated, statistically-oriented approach might be required(2). Whatever the method used, the basic idea is to know the community.

Community Mental Health Organization

A local community mental health center consists of human, capital and ideational resources. Among the most significant are its size and administrative structure, the orientation of its policy makers, the interest, skills and allocation of its staff and its stage of development. The quantity and quality of each of these factors combine to form a unique organization engaged in satisfying mental health needs in interaction with other systems of human activity and resources within a community.

In designing programs the administrator must set explicit goals and see that his facility is effectively organized to accomplish them. Staff must be analyzed to determine if their skills, attitudes and motivations will move the program toward the stated goals. After completing this analysis, an operational strategy must be developed and communicated to the staff. The administrator must determine what actions should be taken, by whom and when.

Social Support Network

The social support network includes institutions and agencies such as schools, the local welfare department, the police department, churches, the YMCA and citizen groups. This network is the vehicle through which many indirect services are delivered. These agencies and institutions are a part of the larger community, as is the community mental health center and the relationships established with them determines the success or failure of a local program of indirect services.

The analysis should consist minimally of a classification of all units of this network by type, location and current relations with each. This procedure will point out gaps in coverage and can indicate the areas of greatest strength and weakness. A more useful appraisal might also include an analysis of each agency's receptivity and commitment to mental health related activities.

Staff members can be an invaluable source of knowledge and should participate in the collection, appraisal and classification of information about the social support network.

OBJECTIVES

The situational analysis should provide an awareness and definition of problems within the community. Based upon this awareness and conditioned by available resources, a program manager is in a position to make meaningful statements concerning what he will try to accomplish. These statements of purpose are the program's objectives.

Statements concerning program purposes, in the past, have been too global and platitudinous. The basic difficulty seems to be the vague manner in which objectives are worded. They are not meaningful to persons assigned responsibility for carrying them out. An example of an aim which is not specifically actionable is the following popular statement: "To prevent mental illness, to reduce the incidence of emotional disorders, and treat persons suffering from mental illness". Although this statement of aim is a noble one, it does not indicate the specific objectives which are to be obtained, and, lacking these, it affords no basis for program emphasis or for evaluation of results. The objective, in general, is too broadly stated. It is not specific enough to be actionable.

No program manager can detail a plan describing how he will accomplish a vague and indeterminate objective. The objective(s) must be identified in such a way that success or failure can be determined. They must be specific, practical (capable of accomplishment), and verifiable. These factors, which must be considered when stating objectives, lead to the necessity of deducing specific planning objectives from broader mental health objectives. Their selection will remain a local matter, but should complement larger departmental goals.

The overall goal or the mission for California's mental health system is given in the following:

> "All Californians will have access to appropriate mental health services that will insure continuity of care and treatment(3)."

This statement is left to the interpretation of each program director. A local program director is logically in the best position to know which services are appropriate to insure continuity of care and treatment. He will have first-hand knowledge of the resources and barriers in his community that impinge upon the accomplishment of the overall goal of California's mental health system. The local Short-Doyle programs will attempt to carry out this mission in a variety of ways, dependent upon the presenting problems in their own communities, but should always seek to work toward this major statement.

After a thorough analysis has been made of the community, after problems and resources have been identified, and after specific objectives have been related to the mental health system's purpose, comprehensive plans can be developed for a program. The following subsection outlines in detail the basic premises and strategy involved in carrying out a program of indirect services. In an actual program effort, this would be only one of many subplans to accomplish overall program objectives.

A PLAN

Objective

Based upon a situational analysis of a community, the newly established mental health organization developed the following long-range and short-term objectives for its indirect services program:

> Within five years to have established working relations with the major community social agents, providing a full spectrum of services. By the end of the first year 30% of staff time to be used in providing case management services. By the end of the second year, 50% of staff time to be spent in providing staff development services to agencies.

Basic Assumptions

No tax-supported community mental health program just happens to come into a community. A sense of need mobilizes certain political and lay forces to establish a community mental health organization. The community understands and expects a program of direct treatment services and minimal time is required for these services to become accepted. The indirect services program, influenced by these expectations must manipulate the environment to stimulate demand for non-treatment services through the careful nurturing of relationships within the community. Change is brought about through information and education services, together with community organization activities to create acceptance and pave the way for more widespread use of the full spectrum of these services. With increased acceptance, management is able to provide increasingly efficient and effective deployment of personnel and services by assisting receptive social agents in providing for the mental health needs of their clients. As change is effected in the environment, direct services can be limited more and more to those acute and unusual cases requiring intensive professional psychiatric treatment.

Strategy

The combination of services presented here represents one of many possible strategies for indirect services. The plan does not impose upon the methodology of rendering services by the practitioner but can serve to assist in determining priorities in his selection of contacts and services within the context of defined program objectives. The pattern of services selected in this plan represents service input for a newly developing community mental health center. The service mix is based upon the following rationale:

1. In the formative period, before and immediately after the establishment of the community mental health center, information and education services receive high priority. The purpose here is to create an awareness of mental health needs by the community and to indicate the availability of mental health services.
2. Community development services also receive high priority initially as staff members collaborate with various agencies, groups and individuals. The initial emphasis on this service is based upon a need for developing and integrating resources and professional specialities within the community.
3. Through provisions of 1 and 2, staff members become identified as potential mental health consultants by other community professionals and establish relationships within agencies through the provision of case management services at the worker level, essentially on a one-to-one basis.
4. Through successful response to requests, consultants build toward a program with emphasis upon staff development services within agencies eventually participating as mental health consultants to persons at the policy level within the community. High input into this service becomes the major ultimate objective. The premise for this objective is the notion that impact will broaden the one-to-one- basis so that many more persons within the community will be affected through each contact made with the mental health professional.

A pictorial view of the timing of service inputs is shown in Figure 6. The upper portion is reserved for a graphic representation of the separate services of the indirect services program. The trend lines represent the pattern of services planned to achieve program goals over a period of time. The input of these services may fluctuate and shift in response to resources and stimuli from within the program itself and through its interaction with other factors in the community. The vertical axis measures the magnitude of input and the horizontal axis indicates the passage of time. Any suitable unit of measurement can be applied.

The lower portion of the graph represents the community, social agencies and the community mental health center's resources. Only negligible shifts are indicated and are intended for illustrative purposes. To be fully operational, the model would require continuous monitoring of each of the related variables.

It can be seen that education-information services gradually shift from high input levels to low input levels but continue to remain a part of the program. Similar input levels are planned for community development services. Case management activities to community agents needing support in times of crisis are a standard service but limited more and more to the acute cases as staff development services begin to have more effect.

Assuming that this pattern of services is effective, changes should occur in the components shown in the lower section of the figure. The following changes are anticipated: The environmental system will be undergoing gradual positive change through favorable community acceptance; members of the support network gradually gain increasing confidence in program staff; increased proficiency of program staff occurs as positive relations develop with the community.

It should be evident to the practitioner that a program's development must progress much as the maturation process of a consultation relationship in establishing itself. Each step of the process is conditioned by the community's readiness and the mental health professionals' awareness of its readiness.

Although it is still impossible to quantify all the factors involved, the experienced mental health professional recognizes the optimal time to move into an agency, into another form of service, or out of an agency. There is also an optimal time when a program can move into the next general phase of development. If either fails to exploit the moment, an opportunity is lost. If effort is not suitably sustained, decay effects set in and that which has been put into the effort is wasted. Management must consider these factors in planning and assessing the ongoing program.

Readjustment of Planned Input

Due to the imperfect state of knowledge about the major variables and the changing nature of the environment, it will frequently be necessary to alter planned service inputs. A plan is not a static entity.

The preceding description of the interplay of services provides the basis for showing readjustments in planning which results from disturbances in one or more of the major variables. Figure 7 is a simplified version of the model in Figure 6, illustrating a negative disturbance in community resources. Although all components of the indirect services portion will be influenced, for simplicity, the indirect services portion of this Figure shows only the services of education and information and of community development. Only the community system is shown in the lower portion.

An example of a disturbance in the community system would be an increase in drug abuse within the adolescent population. The community expresses concern and calls upon the mental health services for assistance in dealing with the problem.

At time T_1 the community system takes a negative shift resulting in a need to adjust input into the services. The service mix is changed to allow more concentration in the areas of education-information and in community planning and coordination. Beginning at time T_1 staff time for these two services has been adjusted upward. At T_2 it peaks and begins shifting back toward the original pattern. The total effect of the disturbance is an extension of that point in time where staff development becomes the predominate service (assuming no further disturbance in the total system in increase in program resources).

MONITORING OPERATIONS

It is obvious that an information system is necessary to utilize this model for effective deployment of both staff and services. Any intelligence system should (1) accurately reflect the operations of the program and (2) report the operations in a manner relevant to decisions managers must make about the program.

After a system of reporting has been developed and experience gained within a particular program, the program director is in a position to make fairly reliable estimates of the variability of his operations. With this knowledge he can begin operating with some degree of control.

One method of monitoring operations is shown by the chart in Figure 8. This chart can be used to indicate when a particular service is in control

Figure 6

PLANNED PATTERN OF SERVICE INPUT INDICATING INTERACTION WITH MAJOR ELEMENTS WITHIN THE RESOURCE NETWORK THROUGHOUT THE PLANNING PERIOD

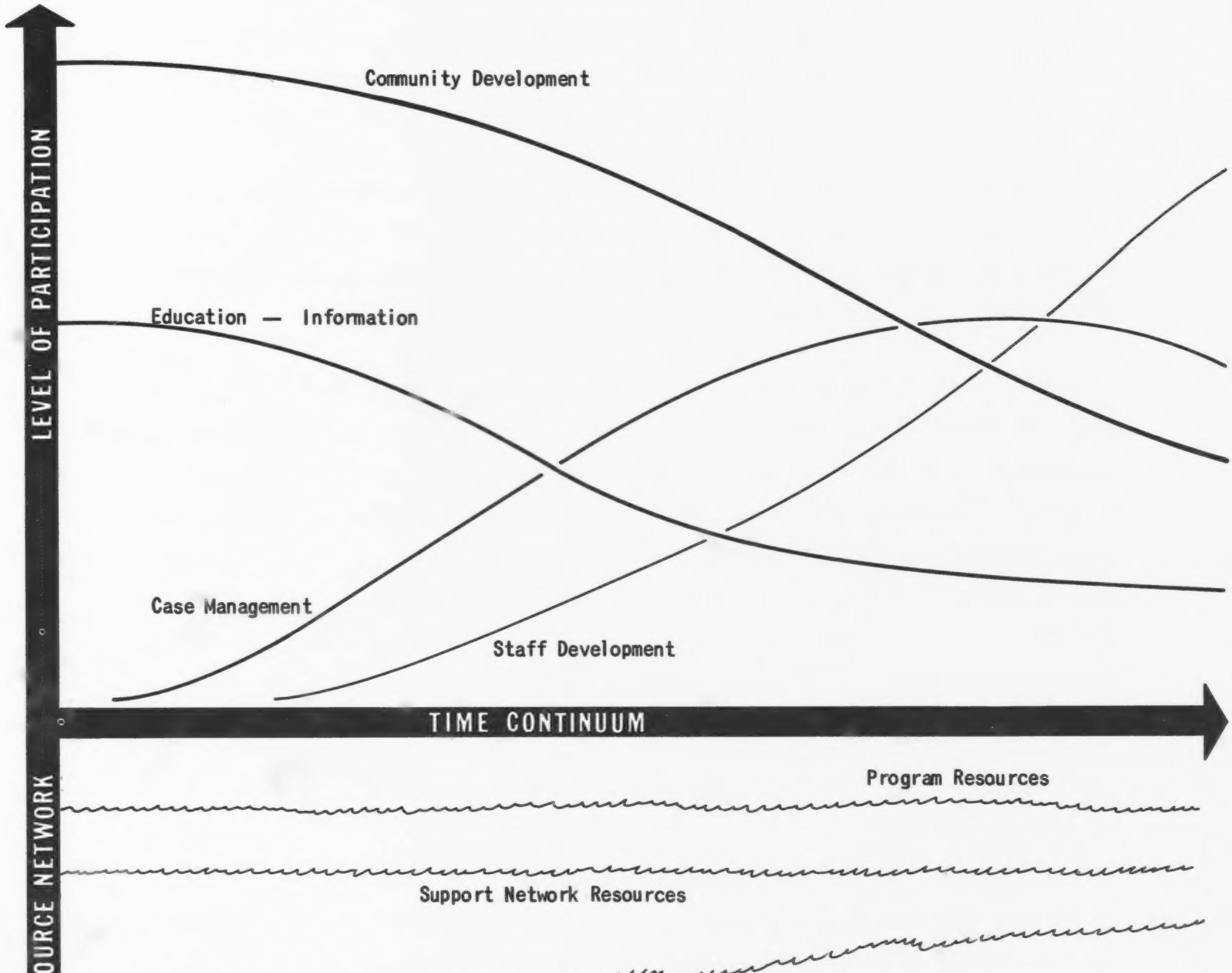


Figure 7

ADJUSTMENT IN THE ORIGINAL PLAN IN RESPONSE TO A SHARP CHANGE WITHIN THE RESOURCE NETWORK

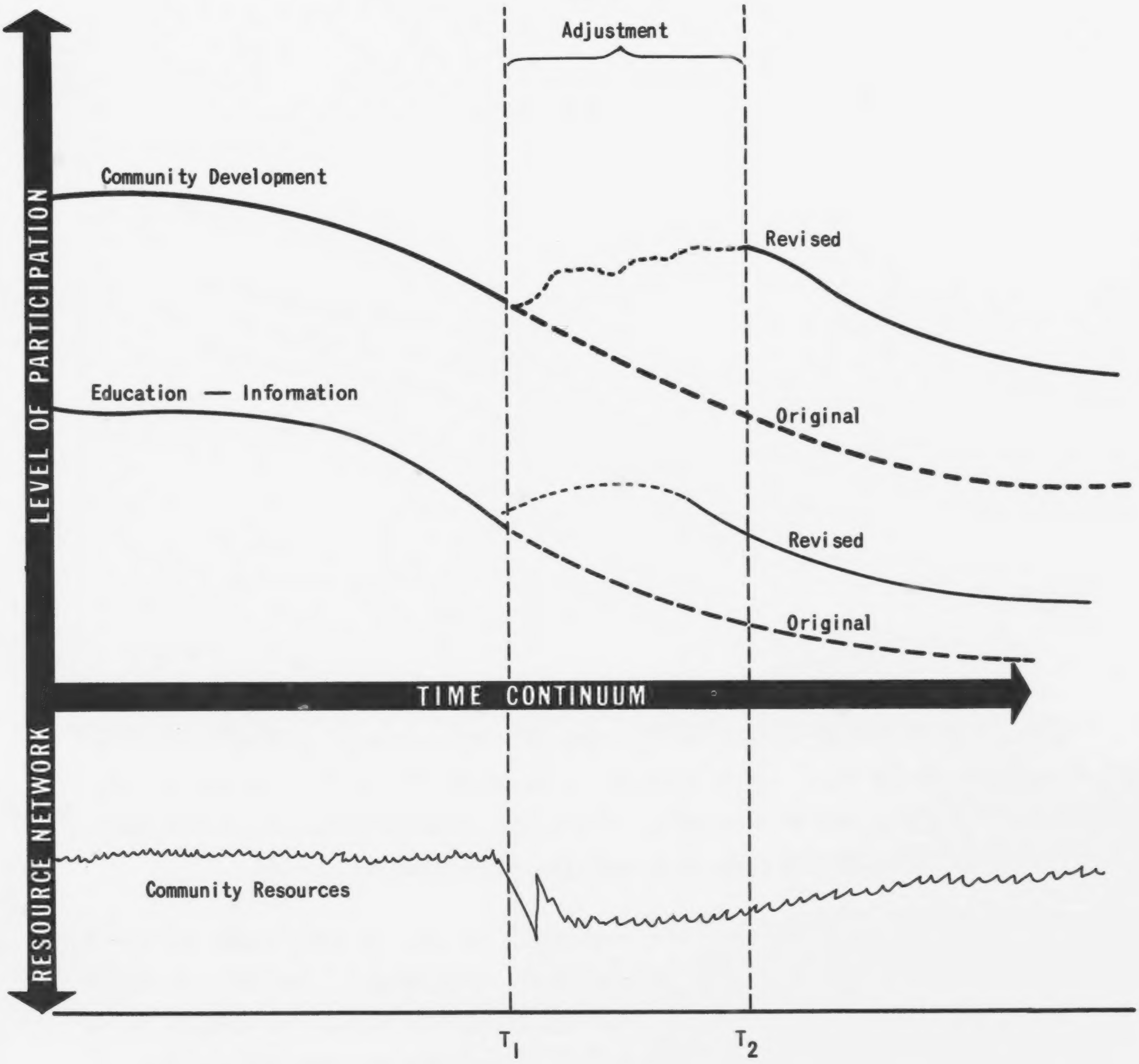
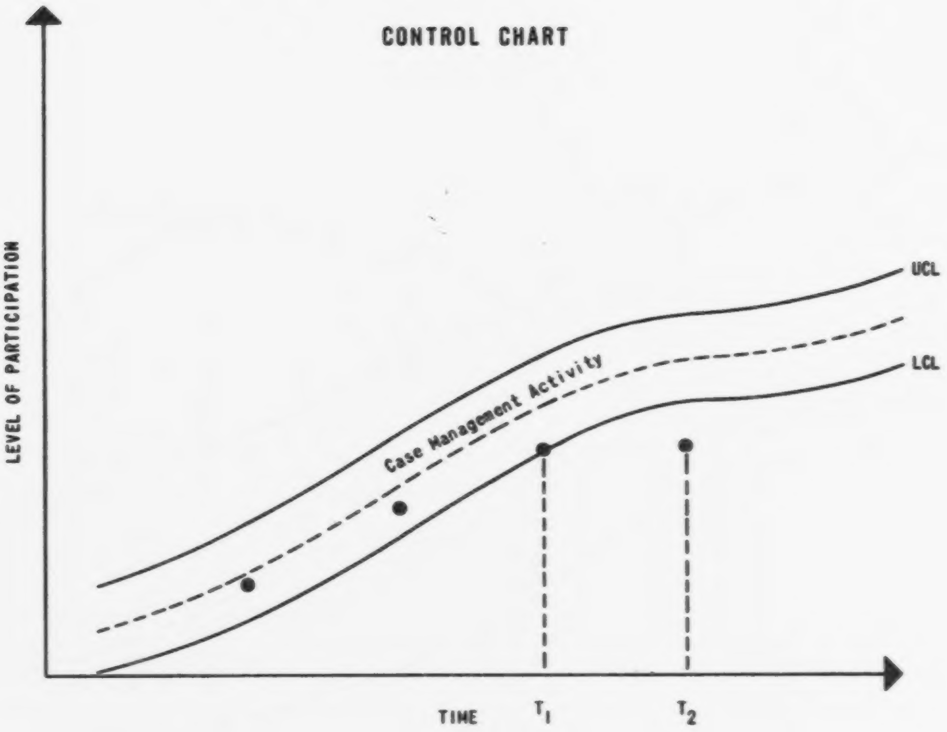

Adjustment
Community Development
Revised
Original
Education — Information
Revised
Original
LEVEL OF PARTICIPATION
TIME CONTINUUM
RESOURCE NETWORK
Community Resources
T_1
T_2

Figure 8



and when it is moving out of control. If the planned level of the service seems to be moving out of the normal operating range, as indicated by reported data, this chart provides a measure of the likelihood of its actually going out of control. Thus, the chart becomes a useful tool for indicating deviations from management's plan of action.

Usual or chance variations are expressed on the control chart in the form of control limits which are subjectively determined. Variations which lie within these limits are due to unassignable causes or normal operating variability. When reported data indicate operations are outside the limits, planned resource input is out of control, automatically signaling a need to investigate the situation. Looking at Figure 8 again, it is obvious that the planned level of service is going according to schedule up until point T_1 on the time axis. At this point, management would see that the service is definitely out of control, and should take remedial action of some kind.

An investigation of wide variation between planned program input and actual input can be useful in determining changes in the support network, shifts in community resources, unrealistic planning premises, and/or unforeseen changes occurring through time. A change in any one of these areas may invalidate the original plan and indicate a need for adjustment.

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1. Davis, Keith: Human Relations at Work, the Dynamics of Organizational Behavior, (3rd ed.), McGraw Hill Book Company, New York, 1967. See for discussion of scientific and professional employees based upon scientific as well as empirical observations. Davis' discussion serves to reinforce and round out our observations of professional attitudes and resultant organizational character.

2. See Comprehensive Planning for Mental Health in Illinois, Progress Report No. 1, Illinois Mental Health Planning Board, January 31, 1966; also Mental Health Data Book, Planning Committee of Santa Clara, California, 1968.

3. California State Department of Mental Hygiene: Newsletter, No. 18, January 22, 1969.

V.

PROBLEMS OF REPORTING

Mental health professionals devote their occupational lives to mastering complex, subtle processes of personal interaction. Reporting systems require the translation of these processes into abstract numbers which, in the eyes of the professional, strip interactions of their essential qualities. Practitioners are uncomfortable, if not fearful, of having their services determined and evaluated on the basis of this kind of accountability. Reporting systems designed to quantify their activities have, at best, been found wanting.

People Problems

Mental health practitioners share a universal dislike for paperwork. Day-to-day recording of routine activity which forms the basis for statistical reports is an onerous chore. Activities must be forced into categories not appropriate to the interacting process being represented. Resultant numerical, analytical reports are suspect. Subtleties of human interaction, which are the substance of professional existence, are not readily amenable to quantification. This approach can result in distortion of reality and may even prove harmful when applied to decision-making. The less-than-devoted response to reporting requirements and each one's awareness of fellow workers' like responses add to the wary attitude toward data. This jaundiced view of statistical data is reinforced by the inability of scientific inquiry to produce clear evidence of the effectiveness of the profession's efforts which, in turn, lead practitioners to consider further inquiry either a waste of time or a threat to their professional value system.

The limited usefulness that routine reports can provide a practitioner, the awareness of the weaknesses inherent in the generation of raw data and the inevitable sense of surveillance inherent in having to account for activity, in combination, create a situation far from conducive to ready acceptance of data as a basis for planning, managing and assessing programs.

The response of consultants and educators to the duty of recording activities for mental health reporting systemsalso seems to be influenced by the service orientation of the program within which they function. Consultants and educators attached to organized units of indirect services are inclined toward some program direction, and are skilled in consultation and education processes. They tend to excercise care in their efforts to record activities appropriately. Frustrations due to inadequacies of the present reporting system are strong, reflecting a need to justify their services, both quantitatively and qualitatively. Competition with the more traditional treatment units reinforces this need. Concentration upon processes as the fundamental bases for a reporting system has led indirect services personnel to doubt that their activities can ever be quantified adequately. They record their activities in an established format, viewing this requirement as burdensome, but necessary.

Individual consultants attached to treatment-oriented programs and staff who have only portions of their time allocated to these services are more inclined to consider indirect services a minor aspect of their program. Their activities give evidence of less cohesive planning and frequently indicate less concern about the distinctions between processes in performing their consultation and education activities. The appropriateness of reporting categories is of less concern to them, and the pressure to justify the indirect service portion of their activities is less acute than that of staff devoting full time to consultation and education. Responsibility for data collection is often delegated to clerical staff who find it necessary to badger the professionals for the needed information.

Rural programs have small staffs who carry responsibility for both treatment and non-treatment services. The type of rural programs which limit direct treatment services to persons referred by social agents in the community make extensive use of consultation and education services in conjunction with treatment services. Their activities are often a blend of consultation and treatment services. The present reporting system does not allow for this possibility and forces considerable distortion in reporting of activities. A major concern of staff in this type of program is the time required in maintaining a reporting system which is patently inappropriate for their activities.

Other rural programs have a strong treatment orientation. Consultation and education services are included in their budgets primarily for the reimbursement potential. In these programs, consultation and education activities are in response to community request. Allocation of staff to these requests is based upon the availability of personnel and their willingness to assume these services. Reporting of these activities is haphazard and of little concern to staff or management.

System Problems

Present data systems in the psychiatric field have evolved from the medical chart. The counts of patients according to social, diagnostic and treatment categories provide information about persons processed through the confines of a medical system. Such data have meaning for those directly responsible for patient treatment services; they are not sufficient for the information needs of administrators managing community mental health programs which are involved with more than treatment services.

Pioneers in the community mental health movement attempted to resolve the conceptual problems of incorporating non-treatment services into the traditional psychiatric establishment by distinguishing between direct treatment services and indirect non-treatment services. In the beginning of the community movement, this concept seemed reasonable. Therapy rarely took place outside the treatment setting; consultation techniques were of foremost concern in developing indirect services. It was feasible to declare that, regardless of the circumstances under which psychiatric treatment took place, it was to be designated as a direct service. Since consultation and education services were viewed as distinctly separate from treatment situations and usually rendered outside the psychiatric facility, the distinction seemed logical.

As programs have become more deeply involved with mental health problems of communities, the distinction between direct and indirect services is less valid. Services are rendered under much less rigid circumstances. Treatment may occur outside as well as inside the treatment facility and, similarly, non-treatment services can take place in either setting. Also treatment may occur in conjunction with non-treatment services. As these services have become more conjointed, the treatment-non-treatment dichotomy has lost much of its original capability to discriminate.

Efforts to classify, dissect and reclassify activities of indirect services into infinitely smaller segments have been a major undertaking in many community mental health programs. Categories of particular services are actually descriptions of the processes involved in performing these services. For example, consultation has been variously classified as case-centered, program-centered, crisis-oriented, client-centered, consultee-centered, collaborative, ad infinitum. Similar examples can be cited for other indirect services. This classification process is especially valuable to practitioners, trainees and researchers who require an understanding of the subtleties involved. However, as these fine gradations are carried over into administrative reporting systems, they become burdensome and administratively inappropriate.

This tendency toward finer and finer gradations has made it difficult to record activities accurately. In practice, often more than one method or process is drawn upon in a single encounter. The mental health professional is forced to make an arbitrary decision as to which category most appropriately reflects the activity for reporting purposes. Since the statement and interpretation of definitions and categories is dependent significantly upon the philosophy, knowledge and training of the professional, inconsistencies in reporting are assured.

Even if reliable data were generated, no rationale exists for converting them into information. The statement that a program has provided 200 hours of client-oriented consultation during a month does little more than account for a portion of the consultation staff's time. This bit of data floats in limbo unless given meaning through some rationale about the relationship of client-oriented consultation to the rest of the program and to the intent of these services within the community.

When evaluated on the basis of standard data collection criteria, the following charges against the existing system for indirect services reporting appear to be justified:

1. The current data system does not provide meaningful comparisons of local activities at the state level.
2. The current data system provides little meaningful information for local use.
    a. Data collected in the local programs provide only limited description of contacts within the community.
    b. Data provide no indicators for evaluating impact of indirect services in the community.

3. The data collected now are not reliable.
    a. Definitions are not discrete.
    b. Reporting within and between programs is not consistent.
    c. Items in the reporting system are inadequate for categorizing activities forcing inconsistencies in the reporting.
4. The data collection has little known validity. There is no clear statement as to what present data are intended to measure.
5. No clearly defined statements have been made, either at the state level or the local level as to the use for indirect services data. Data collected is seldom brought into decision-making at any level with the exception of those few programs which base their budgets for indirect services on actual hours spent in indirect services.

Improvement in routine accounting for services of the kind considered here must overcome process hang-ups, contain categories suitable to activities of a wide range and place these services in juxtaposition with other services of the organization.

VI.

COMMUNITY MENTAL HEALTH INFORMATION MODEL

Reporting systems for indirect services have, to date, been inadequate and ineffectual. Data generated by these systems have been unreliable, inconsistent, and invalid because of the particular conceptual framework around which they are designed.

An alternative to existing reporting models will be presented in this chapter. It has the advantages of being comprehensive, of being divisible into enough sectors to permit logical analysis, and of being functional for managers.

Three major factors distinguish this model from existing systems:

1. The practice of classifying services as either direct or indirect (treatment-non-treatment) is not a part of this model.
2. Reliance on particular techniques or processes as the basis for classifying services is eliminated.
3. The tendency toward finer and finer gradations of activities has been reversed in favor of using only four major service categories.

New Classifications

The ten reimbursable services under the Short-Doyle Act are tools for working toward the goals of community mental health. Reporting systems which treat these tools as ends in themselves have certain built-in assumptions which may or may not be true. For instance, the assumption that persons receiving inpatient services are more acutely disturbed and are receiving a different kind of therapy from persons receiving outpatient services may or may not be a valid assumption. Similar assumptions result in other services available to a community mental health program being viewed as separate and distinct entities, i.e., mutually exclusive events. Nowhere is the fallacy of the latter assumption more pointed than in the area of indirect services. A single contact may involve several services, include both treatment and non-treatment activities and depend upon the use of overlapping techniques for successful completion.

In working through the reporting problems surrounding indirect services it became evident that a treatment-non-treatment dichotomy is not an effective conceptualization around which to build a reporting system. The conceptual design moves far beyond the original effort to quantify indirect services and encompasses the total mental health program within one frame of reference using staff time as the unit of measurement and designating four broad categories of staff activity. This system, combined with the individual patient reporting system, can provide a summary statement of program activities on a routine basis.

Before considering the reporting format, it is essential that the treatment-non-treatment dichotomy of past reporting systems be put out of mind. This dispenses with the use of terms "direct services" and "indirect services" distinguished by therapy and non-therapy activities.

A more useful dichotomy can be made by distinguishing between "in-facility" and "out-of-facility" activities. Several advantages accrue from this conceptual division. First, the facility concept avoids focusing around the nuances of methodology and processes which have resulted in unreliable data. The parameters are broader, permitting ease in classification of activities when several services are performed in a given contact. Second, this conceptualization permits selection of a measuring unit common to both clinical and non-clinical kinds of activities. A common measure should serve to integrate the heretofore separate systems. Also, a more complete and accurate enumeration should result as the need to choose between subsystems is eliminated.

The in-facility setting carries with it a group of resource, planning and management considerations which differ from those involved in providing services out-of-facility. Physical plant, man-hour requirements, personnel qualifications and transportation are only a few of the factors posing different tactical problems. The physical plant is a significant factor in supplying treatment services in the facility. It is of less concern in rendering services out of the community. Transportation and travel time are significant factors in the provision of services within other settings but have little importance in the consideration of in-facility services. Training services in-facility may require plant space and staff scheduling not required for education services to other agency groups. Staff can be assigned and maintained with relative consistency within the clinic. Services rendered out-of-facility may be unscheduled, set by community agents or negotiated between the mental health professional and the agent with less regard for the working routine of the mental health facility. Crisis situations within the community require different entry protocol and resources from those required in an emergency room at the hospital. Information which makes the distinction between in-facility and out-of-facility activities will not eliminate the need for executive judgment; however, such information can facilitate the decision-making process.

The Concept of Jurisdiction

Although the facility terminology has a general locational connotation, it is defined not so much by location as by jurisdictional sanction. The rationale determining the demarcation between in-facility and out-of-facility services is based on the authority governing entry into service.

A community can be viewed as consisting of an aggregate of domains, each with its recognized responsibilities, power structure, defined territory and controlled entry. Each domain has its gatekeepers who screen qualifications of those seeking entry.

Within their established domain, the staff of the mental health facility have prescribed responsibilities for the psychiatric treatment of patients for whom they carry the authority of acceptance or rejection for services. A person desiring entry into patient status at a mental health facility is required to meet certain qualifications (some of which are totally irrelevant to his needs). His type and degree of dysfunction, motivational attitude, age, income and residence may all enter into the determination of his acceptance. His qualifications are evaluated by mental health personnel and if he fails to meet the criteria, sanction to enter this jursidiction is denied by the mental health personnel. If the gate is opened to him, services on his behalf fall into the in-facility class.

The assumption of community mental health responsibilities take mental health professionals into the jurisdictional arena of other agencies and groups. A mental health professional desirous of serving the mental health needs of persons identified with other social agencies is placed in the position of petitioning to provide services in those domains or awaiting the request from others to become involved. He, too, must meet a set of criteria, frequently subtle and ill-defined. His professional classification, age, sex, length of residence in the community, background and personality plus his expertise in presenting his services become involved in the screening process. Permission for his entry into other domains is dependent upon his assumed worth and the suitability of his services in the eyes of gatekeepers of those jurisdictions. Services he renders in other jurisdictions fall within the out-of-facility class.

In determining jurisdictional authority, a basic assumption must be made that all applicants are desirous of entry into the domain of the mental health agency and that mental health professionals are desirous of entering into the other domains. The right of a patient to reject treatment in the mental health domain or of a mental health professional to refuse to render a service in another domain does not alter the jurisdictional determination. If an agent of another domain agrees to meet in the office of the mental health professional for consultation regarding his clients, the service still remains an out-of-facility service because the jurisdictional sanction for using consultation services is within the agent's or his agency's prerogative.

Reporting Categories

The hypothesis that much of emotional disorder is primarily social in origin dominates the formulation of the reporting model. The thesis that community mental health is the responsibility of all social agents justifies the equating of staff development consultation to other agencies with staff development within the mental health organization itself. Improved professional functioning of mental health personnel in behalf of the mental health of agency clients can be considered in the same context as improved professional functioning of mental health personnel in behalf of patients. The depth of technical knowledge and degree of responsibility may differ between the types of professionals but the long-range goal for both is to assist people to become socially competent.

Administrative consultation to other agencies and administrative functioning within the mental health organization also vary in degree and focus but, again, the long-range intent is the same -- to facilitate the delivery of services which advance the recipient's social competence.

The format incorporates services rendered by the mental health staff to patients and community with in-house activities. They can be separated within categories by the jurisdictional division and the definitions of categories.

A general definition of each major category is followed by definitions appropriate to the in-facility and out-of-facility variations upon that definition. Each general category includes a brief explanation of its relationship to the other categories in the model.

Case Management

Activities of mental health personnel applied to mental health problems of specific individuals:

IN-FACILITY	OUT-OF-FACILITY
Activities performed in behalf of a person acquiring patient status with the mental health organization's jurisdiction, exemplified by his suitability to receive a case number or to be billed for services. This status is indicative of the mental health facility's acceptance or responsibility for certain aspects of the patient's welfare. Activities with persons significant to a patient are part of this category so long as the patient is receiving treatment.	Activities performed in behalf of a person outside the mental health organization's jurisdiction. Such service is initiated at the request of someone within another jurisdiction. (A private home is considered another jurisdiction unless the person to be seen is a patient of the mental health facility.)

The determining factor in distinguishing this category from others is that activities here are addressed to the problems of identified persons for whom the mental health personnel or a social agent has the responsibility. The mental health professional, a social agent (or both) has (have) direct contact with the person under consideration. The intent of activities is to produce change which benefits the person, whether the mental health professional directs his efforts toward change in the person or in the agent's pattern of interaction with that person. Any kind of activity -- treatment, consultation, referral, etc., focusing upon or around the person which involves the mental health professional is appropriate to this category.

In distinguishing between the subcategories of in-facility or out-of-facility, jurisdictional authority for permitting the activity must be determined. Services to a person requesting status as a patient of the mental health facility come under the in-facility subcategory. Services requested of the mental health professional by someone in a jurisdiction other than the mental health facility belong in the out-of-facility subcategory. Home visits to patients on the mental health facility caseload belong under in-facility and those visits to persons at home who are not yet patients or will not be recorded as patients as a result of those visits belong under the out-of-facility subcategory. "Staffing" of a case to determine a diagnosis or a pattern of treatment is to be recorded as an in-facility case management activity.

Staff Development

Activities of mental health personnel intended to increase the knowledge and skills of workers for the improvement and protection of the mental health of persons coming within their responsibility:

IN-FACILITY	OUT-OF-FACILITY
Activities carried on within the mental health facility's jurisdiction which are intended to develop and expand the abilities and knowledge of persons participating in the care and treatment of patients or in the provision of mental health services to other jurisdictional agents.	Activities carried on in other jurisdictions by mental health professionals which are intended to develop and expand knowledge and abilities of other professionals to apply mental health principles and techniques to their work.

The determining factor in distinguishing this category from others is that activities here are directed toward persons (including mental health volunteers) carrying or expecting to carry responsibility for particular groups of clients. They may be trained mental health professionals with specific objectives regarding mentally ill or disordered persons or they may be non-mental health professionals such as clergy, social workers and school teachers whose work bring them into frequent contact with people having mental health problems. The general category makes no distinction between in-service training of mental health professionals in other jurisdictions. This is a break from the traditional separation of in-service training in the facility as a part of administrative activities and such activity out-of-facility as a service. The intent in both areas is to better prepare workers to respond to the mental health implications of their responsibilities. The differences lie in the varying degrees of specialization, expertise and responsibility expected from mental health professionals and professionals of other disciplines. Data recorded here under the out-of-facility subcategory of staff development reflect community services in this area in the more traditional sense.

No reporting distinction is made as to the role of the mental health professional in the activity. The activity is recorded if he is leading a session or functioning as a participant. In-service training on a one-to-one teacher-student basis is appropriate to this category.

Situations in which case histories are used primarily as illustrative matter, even though action upon the case may result, are to be recorded under the category of Staff Development.

Program Administration and Development

Activities of mental health personnel intended to develop and maintain programs within the mental health jurisdiction and to influence policies and programs of other agencies which have an effect upon the mental health of high-risk populations.

IN-FACILITY	OUT-OF-FACILITY
Activities focused upon the overall effectiveness of the mental health facility's operations. Operational activities include budgeting, forecasting, research, staffing, recordkeeping, policy and decision-making, goal setting and controlling and evaluating operations.	Activities focused upon consultation and collaboration with administrative staffs of other jurisdictions regarding policies, program planning and development; coordination of community services in behalf of high-risk populations.

The determining factor in distinguishing this category from others is that activities here are directed toward administrative and organizational tasks. The general category makes no distinction between activities intended to improve functions of the mental health facility and activities in participation with existing resources in the community. The intent in both areas is to affect maximum performance and utilization of available resources. The difference lies in whether activities are directed toward improving the efficiency of operations within the mental health facility or are aimed at influencing the entities outside the mental health jurisdiction.

Regional and statewide meetings of the Department of Mental Hygiene which are concerned with policies and administrative changes or program changes belong in the in-facility category. Consultation regarding development of school curricula pertinent to mental health education, for example, should be recorded under the out-of-facility subcategory.

Information and Education

Activities of mental health professionals directed toward informing the general public and educating special interest groups about mental health and mental disorders.

IN-FACILITY	OUT-OF-FACILITY
Activities performed in informing visitors of the facility; preparation of materials to be disseminated outside the facility and staff participation in educational activities of general professional interest.	Activities performed in providing information and educating persons outside the mental health jurisdiction through mass media, seminars, and workshops; consultation to lay groups in development of seminars and workshops.

The determining factor in distinguishing this category from others is that activities here are primarily directed toward the general public. One intent of these activities is to communicate ideas and facts about mental health and the functions of the mental health facility in the community. A second intent is to provide opportunities for special interest groups to increase their level of knowledge about mental health and mental illness. The basic difference between education and staff development is that education concentrates on knowledge underlying the field; whereas, the emphasis in staff development is on increasing professional competence. Education is concept-oriented; staff development is skill-development-oriented.

Reporting Format

This reporting system reflects all professional staff activties based upon a single unit of accountability -- staff time. The reporting form to be used by the staff member can take one of several designs. The suggested sample at the end of this chapter is fashioned after the usual individual appointment calendar; however, administrative activities not requiring an appointment must also be reported on this form.

Each category of the form can be refined to satisfy the needs of the individual, the ward or clinic or the organization. A wide range of subcategories can be created through use of numerical coding within each major category. Representative examples of coded subcategories are included at the foot of the form. By these means, the reporting system can meet the local needs with flexibility and still provide the more gross data required at the state level with compatibility.

The "Summary of Program" format is designed to provide an overview of program activities for a month, quarter or a year. Data for Item II, In-Facility Case Management, come from outside this reporting instrument. The inclusion of individual patient data gives indication of the volume of in-facility patient services rendered by staff within the hours devoted to case management.

Data included in Item III, Out-of-Facility Contacts, provide information about the volume and distribution of staff services to the various types of social agents in the community. The tally of the number of clients considered under out-of-facility case management affords some indication of the number of persons influenced in some manner by this service.

Accounting for the number of new, on-going, closed and renewed contacts with social agents in the community gives evidence of the type of relationships existing between the mental health organization and the community. This accounting, over a period of time, can give indication of trends in community involvement.

This method of reporting permits analysis of programs within the context of the community psychiatry -- community mental health continuum (as defined in Chapter III). It brings patient and community data together with clinical and nonclinical staff activities in a common framework for ready perusal at local and state level.

WEEKLY APPOINTMENT CALENDAR
(INDIVIDUAL)

____
TITLE
(PSYCHIATRIST, PSW)

____
REPORTING UNIT

____
NAME

____
MONTH

DATE HOURS	CONTACT	SERVICE LOCALE CODE	ACTIVITY CODE	STAFF TIME (½ HR. UNITS)	OUT-OF-FACILITY ONLY				
					NUMBER PERSONS SEEN	CLIENTS CONSIDERED IN CASE MGT.(11)	STATUS OF CONTACT*		
							N	O	R

* N = NEW
O = ON-GOING
R = RENEWAL

POSSIBLE CODING SYSTEM

ACTIVITY

IN FACILITY		OUT OF FACILITY
01	CASE MANAGEMENT	11
02	STAFF DEVELOPMENT	12
03	PROGRAM ADMIN. & DEV.	13
04	INFORMATION & EDUCATION	14

SERVICE FOCUS

IN FACILITY

20.0	INPATIENT UNITS (24-HOUR)
20.1	EMERGENCY WARD
20.2	WARD A
20.3	
21.0	DAY CARE
21.1	WARD C
22.0	NIGHT CARE
22.1	WARD D
22.2	
23.0	OUTPATIENT UNITS
23.1	CRISIS INTERVENTION
23.2	DRUG CLINIC
23.3	
24.0	ADMINISTRATION
24.1	GENERAL
24.2	STAFF
24.3	UNIT
24.4	
25.0	OTHER
25.1	RESIDENTS
25.2	VOLUNTEERS
25.3	VISITORS
25.4	

OUT OF FACILITY

40.0	PRIVATE CITIZEN
40.1	CRISIS
40.2	HOME VISIT
41.0	EDUCATIONAL SYSTEM
41.1	ELEMENTARY SCHOOL
41.2	NURSERY SCHOOL
42.0	CORRECTIONAL SYSTEM
42.1	COURT
42.2	PROBATION
42.3	
43.0	SOCIAL SERVICE & WELFARE
43.1	FAMILY SERVICE
43.2	WELFARE DEPARTMENT
44.0	HEALTH & MEDICAL SYSTEM
44.1	PHYSICIAN
44.2	PUBLIC HEALTH NURSE
45.0	COMMUNITY PLANNING AND DEVELOPMENT GROUPS
45.1	COMP. HEALTH PLANNING
46.0	OTHER
46.1	RECREATION
46.2	CLERGY

MONTHLY SUMMARY OF PROGRAM

(For Local Administrators and State Agency)

Reporting Unit ____________________ Month ____________________

In-Facility and Out-of-Facility Staff Time by Profession

I. Activity:	Psychiatrist		Psychologist		PSW		MH Education		MH Nursing Cons.		Other	
	In	Out	In	Out	In	Out	In	Out	In	Out	In	Out
Case Management												
Staff Development												
Program Admin. & Development												
Information & Education												

II. In-Facility Case Management

Type of Treatment Service

A. Patients	24-Hour	Day Care	Night Care	Outpatient
First of Month Caseload				
Patient Days				XXXXX
Interviews				
Month-end Caseload				
Number of Patients Served				

III. Out-of-Facility Contacts

Number of Contacts by Type of Service

A. Type of Community Contact:	Case Management		Staff Development	Program Admin. and Development	Information and Education
	Contacts	Clients			
Private Citizen		XXX			
Educational System					
Correctional System					
Social Service & Welfare System					
Health & Medical System					
Community Planning & Develop.					
Other (clergy, recreation, etc.)					

B. Contact Status: ________ New; ________ On-going; ________ Closed; ________ Renewed

ANNOTATED BIBLIOGRAPHY

ANNOTATED BIBLIOGRAPHY

Abramovitz, A. B.: Methods and Techniques of Consultation, *American Journal of Orthopsychiatry*, Vol. 28, 1958, pp. 126-133.

This article presents eight objectives of consultation. The author points out some reasons why consultants differ from consultees and explains that this is why they are effective. These reasons are generalized and are due to background orientation.

Argyris, Chris: Explorations in Consulting-Client Relationships, *Human Organization*, Vol. 20, Number 3, 1961, pp. 121-133.

A study of the role of the consultant based on analysis of two cases of a consultant group, with an ultimate goal of developing "appropriate models to understand the client-consultant relationship and its impact on organizational change and development". The selection of cases is not a random one, but "is specifically loaded in the direction of cases that illustrate the difficulties which consultants face". Consultants' files and personal notes, and interviews and discussions with them were used. The study is limited to those consulting relationships within the organization. The difficulties of the consultant's role, the marginal role of the consultant and the emphasis on the process of development are discussed.

Baker, Frank and Herbert C. Schulberg: The Development of a Community Mental Health Ideology Scale, *Community Mental Health Journal*, Vol. 3, Number 3, Fall 1967, pp. 216-225.

A scale is presented of 38 statements which purports to measure the degree of orientation toward community mental health. Items are built from five conceptual categories: a population focus, primary prevention, social treatment goals, comprehensive continuity of care, and total community involvement.

Berlin, I. N., M.D.: The Theme in Mental Health Consultation Sessions, *American Journal of Orthopsychiatry*, Vol. 30, 1960, pp. 827-828.

The author feels that the consultation session usually has a central theme which, when understood, reveals the conflicts of the consultee which prevent adequate functioning on the job, and when understood and responded to by the consultant, helps the consultee in his work.

Berlin, I. N., M.D.: Mental Health Consultation with a Juvenile Probation Department, *Learning and Its Disorders*, Palo Alto, California: Science and Behavior Books, Inc., 1965, pp. 157-166.

Dr. Berlin discusses the issues confronted by and the ways of dealing with probation officers in a juvenile probation department.

Berlin, I. N., M.D.: What Help Can the Educator Expect from the Mental Health Specialist, Learning and Its Disorders, Palo Alto, California: Science and Behavior Books, Inc., 1965, pp. 72-79.

A brief discussion of some unrealistic and realistic expectations between educators and mental health specialists in a collaborative relationship.

Berlin, I. N., M.D.: Mental Health Consultation in Schools as a Means of Communicating Mental Health Principles, Learning and Its Disorders, Palo Alto, California: Science and Behavior Books, Inc., 1965, pp. 100-108.

This paper is concerned with the particular way in which the consultation process lends itself to the communication of certain mental health principles to the teacher and administrator and often through them to other members of the school faculty.

Berlin, I. N., M.D.: Some Learning Experiences as Psychiatric Consultant in the School, Learning and Its Disorders, Palo Alto, California: Science and Behavior Books, Inc., 1965, pp. 80-99.

The initial effort consisted of working with the school administrators as a group with the hope of uncovering and discussing staff problems. It was finally agreed that this approach was ineffective because each member was interested in his own particular experience. Another approach was tried using the teacher's problem cases as a catalyst for discussion. This approach worked quite well and enabled the administrators to see how the teachers viewed the administrative policies.

Bloom, Bernard L., Ph.D.: Mental Health Program Evaluation: 1955-64 - "A Review of the Literature and an Annotated Bibliography".

Provides definition of evaluation, lists essential questions to be answered by an evaluation study, provides organization models, discusses types of evaluation studies with inherent problems including an annotated bibliography.

Brickman, Harry R.: Community Mental Health - The Metropolitan View, American Journal of Public Health, April 1967, Vol. 57, Number 4, pp. 641-650.

Dr. Brickman, Director of Los Angeles County Department of Public Health discusses the organization and operation of community-based mental health centers in Los Angeles County.

Program growth has been directed by a conservative development policy and emphasis on major mental illness. Educating the care-giver to do his job using up-to-date techniques and the latest knowledge is one area of program emphasis. This is carried out via consultation activities. The author goes so far as to say that extensive use of consultative services may result in "ultimate liquidation of mental health programs altogether".

Caplan, Gerald: Principles of Preventive Psychiatry, New York: Basic Books, Inc., 1964, pp. 212-265.

A process oriented model of preventive psychiatry is presented with a breakdown of typologies and phases to work through.

Caplan, Gerald: Harvard School of Public Health, Workshop on Mental Health Consultation to Teachers, Paper sponsored by Research Project Study of Emotionally Disturbed Children, California Department of Education, Los Angeles State College, September 1, 1959, Nate Sloat.

Mental health consultation is defined as the efforts of a mental health consultant to help the consultee understand cases which constitute problems. The goal is to enable the consultee to handle these classes of problems and situations better in the future. The goals of the mental health consultant are to help present problems plus educate the consultee. The various types of consultation are outlined.

Caplan, Gerald: Problems of Training in Mental Health Consultation, Concepts of Community Psychiatry, A Framework for Training, U. S. Department of Health, Education and Welfare, 1965, pp. 91-108.

A discussion of the issues and problems which were encountered in the development of a training program for consultants. Topics include: 1) the development of techniques, 2) conceptualization and definition, 3) the need for evaluative research, 4) training, and 5) problems in changing from psychotherapy to consultation.

Cathell, J. L., and N. E. Stratas: Mobile Psychiatric Consultation, Education for Primary Physicians, Community Mental Health Journal, Vol. 3, Number 3, 1967, pp. 226-230.

A successful pilot project in which a psychiatrist met with physicians in "any convenient place" to provide consultation-education training on basic psychiatric skills.

Craig, Ray: Consultation and Education, A Service of the Community Mental Health Center, NIMH Mental Health Services, San Francisco, California.

Mental health needs and services, before the concept of community mental health was developed, were severely out of balance. Consultation and education can redress this balance. The extension of medical, psychiatric and social services into the community can strengthen health insights of community service professionals. These factors can help control harmful influences and make stronger the helpful ones that affect the mental health of individuals and groups. Consultation and education can link people of community, both ill and well, with its local mental health specialists and services.

Cunninghan, John T.: Measuring Public Relations Results, A MA Management Bulletin, Number 110, General Management Division, Measuring Management and Evaluating Public Relations Activities, 1968.

In order to evaluate management effectiveness, the author suggests analyzing the following six areas:

1. Objectives
2. Organization structure to achieve objectives
3. Policies and procedures to provide proper coordination and development of programs
4. Availability, training, and quality of people to carry out programs
5. Programs themselves
6. Results to keep entire operation on course

Daniels, David N.: The Community Mental Health Center in the Rural Area: Is the Present Model Appropriate?, American Journal of Psychiatry, Vol. 124, Number 4, 1967, pp. 32-37.

Direct clinical services do not meet the needs of rural communities. An indirect services model is proposed which emphasizes consultation, education, preventive and community psychiatry, and community organization.

Davis, Keith, Ph.D.: Human Relations at Work - The Dynamics of Organizational Behavior, McGraw-Hill, Third Edition, 1967, 559 pages.

This book deals mainly with human relations as the interaction of people in all types of endeavor - in business, government, social clubs, schools and homes. As discussed here, human relations "is the study of human behavior at work and an effort to take action in operating situations in order to produce better results".

Elinson, Jack, Elena Padilla, and Marvin E. Perkins: Public Image of Mental Health Services: New York: Mental Health Materials Center, Inc., 1967.

This survey indicates that traditional public rejection of the mentally ill is beginning to decline. This report deals with the public's experience with help for mental or emotional disorders, the public image and knowledge of mental health facilities and professionals, how the public views the newer kinds of treatment and rehabilitation services and programs, and popular concepts and perceptions of mental illness.

Elkins, Alan M., and Papanek, George O.: Consultation with the Police; An Example of Community Psychiatry Practice, American Journal of Psychiatry, Vol. 123, Number 5, November 1966, pp. 531-535.

The authors show the psychiatrist's potential contribution as consultant to community agents lies in his understanding of communication problems among individuals and groups. This example involves the local police force and the community it serves. Communication between community and police force officers was facilitated through educational seminars, lectures, and classes.

Gaupp, Peter G.: Authority, Influence and Control in Consultation, Community Mental Health Journal, Vol. 2, Number 3, Fall 1966, pp. 205-210.

Power is the common factor in the interrelated concepts of authority, influence, and control. Informal, implicit power involves a different set of psychological considerations than does formal power. However, either source of power results in high expectations on the part of the consultee.

Glasscote, Raymond: The Joint Information Service of the APA and NAMH, The Community Mental Health Center - An Analysis of Existing Models, Washington D.C., 1964, pp. 1-213.

The Joint Information Service (JIF) presented models of eleven successful community mental health programs for the purpose of helping shape the development of new facilities and programs now in the planning stage. In addition to these models, the general evolutionary phases of this type of facility were discussed.

Glidewell, John C., Ph.D., and Herbert R. Domke, M.D., M.P.H., F.A.P.H.A.: Health Department Research in Community Mental Health, American Journal of Public Health, March 1958.

This article deals with measuring improvement in mental health. It takes into account the pattern of multidimensional attributes and attitudes involved in the measurement. There are a series of steps to be followed:

1. Ask staff to specify its objectives - to identify the kind and extent of change which they expect to evoke in the communities they serve.
2. Specify precisely the changes which would be accepted as evidence of improved mental health.
3. Define improvement in multidimensional terms.
4. Make hypothesis in regard to improvement.
5. Use those disciplines which are familiar with the problems faced.
6. Make use of cross-consultation between researcher and counselor.

Glidewell, John C.: The Entry Problem in Consultation, Journal of Social Issues, Vol. 15, Number 2, 1959, pp. 50-59.

The entry of the consultant is similar to the attachment of a person to an existing social system. It is suggested that the entry problems can be defined in terms of the fit between the consultant and the client social system with respect to the following variables: (1) perception of need, (2) perception of prospective equity of role, resource and reward distribution, and (3) perception of prospective appropriateness of feeling interchanges with special concern about dependency and counter-dependency.

Goldstein, Harris K.: Criteria for Evaluating Research, Social Casework, November 1962, pp. 474-478.

Criteria are suggested for evaluating research which are applicable to studies in all fields.

Goldston, Stephen E.: Mental Health Education in a Community Mental Health Center, *American Journal of Public Health*, Vol. 58, No. 4, April 1968, pp. 693-699.

Potentially all mental health workers can perform educational tasks and they should be made aware of this potential function in community mental health work. In addition, there are tasks for a trained mental health educator. A discussion is included which describes the lines along which such training could be provided.

Griffiths, William: *The Public Health Educator in Mental Health*, 10 pages, November 14, 1959.

Hall, William B.: Employee Self-Appraisal for Improved Performance, *Tools for Improved Personnel Relations*, (New York: American Management Association, 1951) pp. 29-34.

Self appraisal is one part of a four-step performance appraisal plan. Each employee completes an appraisal of himself, on prepared forms.

Experience with this method yields the following results:

1. Staff will provide accurate and correct information.
2. Enables employees to give their opinions, work preferences and grievances.
3. Self-analysis encourages self-improvement and development.

Hallock, Arthur C. K., and Vaughn, Warren T.: Community Organization - A Dynamic Component of Community Mental Health Practice, *American Journal of Orthopsychiatry*, Vol. 26, 1956, pp. 691-706.

Halpert, Harold P.: *Comprehensive Mental Health Planning in Six States*, United States Department of Health, Education, and Welfare - Public Health Services, Number 1686, 1965.

During a two-year period the official mental health agency in each state assessed its needs and resources and developed a plan for future action and evaluation for the aid of federal matching grants. This program was to encourage the process of planning and the implementation of plans. Fifty states participated but only six were studied in detail.

Harris, Robert M., Betty L. Kalis, and Lida Schneider: Training for Community Mental Health in an Urban Setting, *American Journal of Psychiatry*, Vol. 124, Number 4, 1967, pp. 20-29.

The large investment in community mental health requires that significant numbers of specialists be trained and that all mental health professionals acquire skills in the method and theory of community mental health. The training program at Langley-Porter (California) is described as a preferred program.

Herzog, Elizabeth: *Some Guide-Lines for Evaluative Research*, Washington D.C., U.S. Department of Health, Education and Welfare, Social Security Administration, Childrens Bureau, 1959, pp. 1-96.

This report is concerned with evaluative research methods and findings with particular attention given to psychotherapy. It offers broad and well-recognized statistical guidelines as well as definitive terms.

Hirschowitz, Ralph G.: Psychiatric Consultation in the Schools, *Mental Hygiene*, April 1966, pp. 218-225.

The author illustrates the differences between two high schools in terms of organization, client-income, and social background. He also emphasizes the need for consultants to become "educated" in the background and structure of the organization they are serving.

Howe, Louisa, P.: Problems in the Evaluation of Mental Health Programs, found in Ruth Kotinsky and Helen Witmers (eds), *Community Programs for Mental Health*, Cambridge University Press, 1955.

This article is a documentation of the elusiveness and the complexity of the problems faced in evaluating mental health programs. The vagueness of these problems and the corresponding complexities connected with research techniques are brought out clearly. The relationship of evaluation techniques to program objectives, along with underlying therories are discussed in detail.

Howe, Louisa P.: The Concept of the Community: Some Implications for the Development of Community Psychiatry, *Handbook of Community Psychiatry and Community Health*, Leopold Bellak, M.D., Grune & Stratton, (eds), N.Y., 1964, pp. 16-46.

Dr. Howe suggests that a community psychiatrist needs to have a conceptual grasp of the community that is analogous to the psychotherapist's understanding of personality. She analyzes the community and the role played by the psychiatrist in relation to the community.

Jackson, Jay, M.D.: Some Issues in Evaluating Programs, *Hospital and Community Psychiatry, June* 1967, pp. 23-30.

Professor Jackson raises some issues which should be considered prior to participation in program evaluation. These issues take the form of the following basic questions:

1. Why should evaluation take place?
2. Who should evaluate programs?
3. What are the characteristics of the social phenomena called programs?

Kazanjian, Vard, Stein, Sherry, and Weinberg, William L.: An Introduction to Mental Health Consultation, Public Health Monograph Number 69, U.S. Department of Health, Education and Welfare, Public Health Service.

Consultation is contrasted with psychotherapy, supervision, administration and collaboration. The phases in consultation are: (1) preparation, (2) beginning, (3) problem solving, and (4) termination.

Koontz, Harold and Cyril O'Donnel: Principles of Management, An Analysis of Managerial Functions, Fourth Edition, McGraw-Hill, 1968, 822 pages.

An approach to the process of managing based on the classical orientation. Management is broken into the functions of planning, organizing, staffing, directing, and controlling.

Lippitt, Gordon, L.: A Study of the Consultative Process, Journal of Social Issues, Vol. 15, Number 2, 1959, pp. 43-50.

An exploration of the "psychological dimensions" in the consultation process: (1) the consultant should be assigned to the client group on a continuing basis, (2) it is desirable to build in subgroup action to reinforce the relationship between the consultant and client group if the consultation is done over a long period of time, (3) consultant must work within frame of client group, and (4) it is best to have a formal beginning and end to the consulting relationship.

Loomis, S. Dale: Psychiatric Consultation in a Delinquent Population, American Journal of Psychiatry, Vol. 123, Number 1, July 1966, pp. 66-70.

The role of a psychiatric consultant in a training school is reviewed; particular attention is paid to 240 evaluations of juvenile and adolescent male delinquents. Suggestions as to how to make the consultant more useful include: participation in the training of full-time personnel to treat more effectively and to participate in the correctional program with more insight.

Mackey, Richard A., and Ferdinand R. Hassler: Group Consultation with School Personnel, Mental Hygiene, July 1966, pp. 416-420.

Deals with a consultation program carried out through the use of a discussion group. The care-givers were able to commit themselves to improving their own helping roles. The consultant acted as a supporting agent attempting to involve all members in the discussion.

MacMahon, Brian, M.D., et. al.: Principles in the Evaluation of Community Mental Health Programs, American Journal of Public Health, July 1961.

This article provides a statement of the principles that must guide evaluation of community mental health programs. As shown in the following classification, these principles are broad and general.

1. Determine what type of evaluation is required.
   a. Evaluation of accomplishment.
   b. Evaluation of technique.
2. Definition of the program, population served, and effects desired.
   a. What it is.
   b. What are its intentions.
   c. Results should be observable.
3. Choose comparison groups which will permit inferences required by accomplishment evaluation.
   a. Compare with groups not exposed to the program through a random selection process.

Maddux, J. F.: Psychiatric Consultation in a Rural Setting, American Journal of Orthopsychiatry, Vol. 23, 1953, pp. 775-784.

The author discusses the problems and developments of psychiatric services in rural areas due to geographical size and some internal problems. The paper was based on a two-year experiment in a rural community where no psychiatric service had been present before.

McGavran, Edward G., M.D., M.P.H., F.A.P.H.A.: Research and Public Health Practice, American Journal of Public Health, March 1958.

Dr. McGavran stresses the importance of viewing the community as a "patient" in connection with public health practitioners.

Diagnosing and treating health conditions of the community through the scientific method is the theme of his paper. His breakdown of the method is as follows:

1. Know that the community wants diagnosis.
2. Superficial examination of community.
3. What are community needs (as felt by community).
4. Examine and study available records.
5. History and examination of the community.
6. Tentative diagnosis.
7. Special studies and research.
8. Written diagnosis.
9. Determine priority of needs.
10. Follow-up and evaluate prescribed treatment.

McGregor, Douglas: An Uneasy Look at Performance Appraisal, Harvard Business Review, Vol. 35, Number 3, May-June 1957, pp. 89-94.

The conventional approach to performance appraisal is criticized. Mr. McGregor shows that the manager is in the untenable position of judging the personal worth of subordinates and of acting on the basis of his judgements. Most managers do not have the skill to carry out this responsibility.

A newer approach places the responsibility of appraisal upon the individual. The individual sets goals for himself for a given time period and assesses his achievement at the end of this period.

The newer method is said to result in increased motivation and more effective development of subordinates.

Mendel, Werner, M.: Psychiatric Consultation Education - 1966, American Journal of Psychiatry, Vol. 123, Number 2, August 1966, pp. 150-155.

This is an investigation of the type and extent of consultative training taking place in 202 psychiatric training centers throughout the U.S. Questionnaire responses indicated that 75 percent of these centers offered consultation education. Also, the training was done on an informal, supervisory approach.

Moe, Edward O.: Consulting with a Community System, A Case Study - Journal of Social Issues, Vol. 15, Number 2, 1959, pp. 28-35.

A case study of consultation with a Northwestern community from 1948-1955, employing the view of a community as a social system "in which certain elements, such as goals, norms, roles and authority-power are observable, and in which certain basic processes such as communication, decision-making, systemic linkage, and boundary maintenance are operating". The community includes a great many different systems within it; it is not structurally and functionally centralized in the same sense as a formal organization, and as a social system it is implicit in nature rather than explicit as is a formal organization. Work with the community "poses in one way or another, all the problems confronted in consultation".

Mouw, Mildred L., and Clarice H. Haylett: Mental Health Consultation in a Public Health Nursing Service, American Journal of Nursing, Vol. 67, Number 7, July 1967, pp. 1447-1450.

In definition and planning of local mental health centers it was recognized that psychiatric treatment alone was inadequate in solving the total problems of mental illness. Public health nurses function in the community and have frequent contact with emotionally disturbed individuals. In this particular setting (San Mateo County) a psychiatric consultant met with the staff of a public health nursing service.

Nyswander, Ph.D.: The Dynamics of Planning in Mental Education, *California's Health*, Vol. 13, No. 7, October 1, 1955, 4 pages.

Dr. Nyswander stresses basic assumptions that are crucial to successful planning. She also discusses the meaning of the planning process for the health educator.

Parker, Beulah: The Value of Supervision in Training Psychiatrists for Mental Health Consultation, *Mental Hygiene*, January 1961, pp. 94-100.

This article is based on the philosophy that personnel who have not received psychological orientation as a specific part of their professional training will profit most from learning about normal and abnormal psychological development, behavioral motivation and patterns of emotional expression if the learning is closely related to practical problems encountered on the job. A consultation program must include both education of the personnel along the lines most useful to them and an opportunity for them to experience psychological insights within the framework of a group which has supportive leadership by a psychiatrist. Supervision was considered an important part of the program.

Parker, Pauline E. and Barry D. Terranova: Program Activities in Selected Mental Health Services in California, *Community Mental Health Services in Action*, Division of Local Programs, Department of Mental Hygiene, State of California, January 1969.

Phillips, Derek, L.: Identification of Mental Illness: Its Consequences for Rejection, *Community Mental Health Journal*, Vol. 3, Number 3, 1967, pp. 262-266.

Data indicated that ability to correctly identify behavior as mental illness is associated with rejection rather than acceptance.

Prince, Thomas R.: *Information Systems for Management Planning and Control*, Illinois: Richard D. Irwin, Inc., 1966.

This publication focuses upon information used in the decision-making process and the information flow associated with this process throughout the firm.

Rapoport, Lydia, (ed): Consultation in Social Work Practice, National Association of Social Workers, 2 Par Avenue, New York 16, New York, 1963.

Presents the essential nature of consultation as social work activity and includes examples of current consultation practices.

Robbins, Paul R. and Esther C. Spencer: *Consultation*, California Public Health with cooperation of School of Public Health, University of California at Berkeley, December 1965. Funded by Public Health Service (Grant CH00022).

Concentrates on consultation at program level. Describes the essentials of consultation, a model for predicting the effectiveness of consultation and descriptive questions of consultations.

Roberts, Leigh M., Leymour L. Halleck, and Martin Loeb, (eds): *Community Psychiatry*, Madison: University of Wisconsin Press, 1966.

A presentation of the proceedings of a conference held at the University of Wisconsin in 1964. The central theme: Community Psychiatry - What it is and what it is not. Community psychiatry is defined and presented within the context of several models. Related areas such as training, boundaries, and resistance are also discussed.

Rosen, Beatrice M., Jack Wiener, M.A., Catherine L. Hench, Shuley G. Willner and Anita K. Bohn, Sc.D.: A Nationwide Survey of Outpatient Psychiatric Clinic Functions, Intake Policies and Practices, *American Journal of Psychiatry*, 122,8, February 1966 (Reprint in file).

A survey of outpatient clinic activities in terms of principle clinic functions as of April 30, 1963. Findings are seen as a survey of the perceptions of clinic staffs about the role and functions of outpatient psychiatric clinics across the nation.

Rosenfeld, J. M., and Gerald Caplan: Techniques of Staff Consultation in an Immigrant Children's Organization in Israel, *American Journal of Orthopsychiatry*, Vol. 24, 1954, pp. 42-62.

This is an account of a technique of staff consultation which was developed in Israel about 1953. It centers around a mental hygiene service provided for Youth Aliyah, the national organization responsible for 16,000 unaccompanied immigrant children. Consultation is provided for instructors who must handle difficulties (in a child) which he has not satisfactorily dealt within himself.

Schulberg, Herbert C., Gerald Caplan, and Milton Greenblatt: Evaluating the Changing Mental Hospital - A Suggested Research Strategy, *Mental Hygiene*, Vol. 52, Number 2, April 1968, pp. 218-225.

This article suggests that inpatient-outpatient analyses of statistical data that also consider the effect of intervening variables associated with program structure can produce a more comprehensive evaluation of program operations. A social system orientation is coupled with the traditional use of biometrics.

Shulberg, Herbert C. and Henry Wechsler: The Uses and Misuses of Data in Assessing Mental Health Needs, *Community Mental Health Journal*, Vol. 3, Number 4, Winter 1967.

This article examines the implications of the 1964 Federal Regulation (HEW 1964) in terms of the assumptions made about mental illness and about the planning process. The difficulties and limitations are first discussed followed by the conclusion that these regulations will ultimately broaden the planners' definition of community need.

Shulberg, Herbert C., and Frank Baker: Varied Attitudes to Community Mental Health, *Archives of General Psychiatry*, Vol. 17, Number 6, 1967, pp. 658-663.

This article attempted to determine whether the term "community mental health" contains delineable, agreed-upon characteristics. It was found that mental health personnel with advanced training were more apt to describe the term as having value than were professionals chosen from random samples.

Seney, Wilson: *Effective Use of Management Consultants*, New York: Financial Executives Research Foundation, 1963, pp. 83-89.

This publication is concerned with evaluative techniques under varying circumstances. In situations where there are no possible quantitative measurements, evaluations are made subjectively. Criteria and methods of ongoing evaluation are presented.

Slotkin, Elisabeth, J.: Illinois Department of Mental Health, Division of Planning and Evaluation Services, *Manual for Evolution of Mental Health Programs*, 1966.

This publication describes in detail, a methodology for evaluating mental health programs.

Smith, Brewster M.: The Revolution in Mental Health Care -"A Bold New Approach?" *Transaction*, April 1968.

The author expresses the fear that community mental health movement may be failing. The major reason for this failure is the notion that effective community health cannot be fitted inside existing professional biases, habits, and territorial rights. He feels that more flexibility is required if the new movement is to progress.

Smith, Brewster and Nicholas Hobbs: The Community and the Community Mental Health Center, *American Psychologist*, June 1966, APA's position paper on Community Mental Health.

This article has been accepted as the American Psychological Association's position paper on community mental health. Mental disorder is viewed as rooted in social systems and a responsibility of the mental health center staff should be to help various social systems to function in ways that develop and sustain individuals and to help community systems regroup their forces to support persons who run into trouble.

Weinberg, William L.: *An Introduction to Mental Health Consultation*, Public Health Monograph No. 69, U. S. Department of Health, Education and Welfare.

The purpose of the article is to synthesize some of the current thinking about mental health consultation. It includes definition, purpose, phases, qualifications, principles, guidelines and professional problems.

Whisler, T. L., and S. F. Harper, (ed): *Performance Appraisal Research and Practice*, New York: Holt, Rinehart and Winston, 1962.

A discussion of techniques involved in performance appraisal.

Whittington, H. G.: The Third Psychiatric Revolution - Really? A Consideration of Principles and Practices in Community Psychiatry, *Community Mental Health Journal*, Vol. 1, Number 1, 1965, pp. 73-80.

Differences in emphasis and in deployment of professional resources characterize recent trends. However, there have been no radical changes in practices, skills, or knowledge.

Wolfe, Harvey E.: Consultation: Role, Function, and Process, *Mental Hygiene*, January 1966, pp. 132-134.

Consultation is broken down into three interdependent operational aspects: role, function and process. Role refers to who the consultant thinks he is and who others think he is. The consultant should serve as a catalyst, stimulator, and motivator of ideas. The major functions of the consultant are: evaluating, advising, teaching and liaison.

Woodward, Luther E., and Winnifred W. Arrington: Consultation in the Planning and Expansion of Clinics, *American Journal of Orthopsychiatry*, Vol. 24, 1954, pp. 153-164.

Brief description of what takes place in consultation with community groups which are planning new clinics and other levels which are planning to expand or improve existing services.

Yolles, Stanley, F.: Community Mental Health Services: The View from 1967, *American Journal of Psychiatry*, Vol. 124, Number 4, pp. 1-7.

A view of 256 mental health centers funded during the last few years under federal grants. Diversity of local needs has resulted in diverse methodology and flexibility on meeting these needs. Federal regulations have had little effect on this flexibility.

American Journal of Public Health: Educational Qualifications and Functions of Public Health Educators, Vol. 47, No. 1, January 1957, pp. 1-8.

This report discusses the broad scope of mental health education and the many functions of the mental health educator. It also stresses the importance of a solid educational background and mentions pertinent college courses. Desirable personal qualities of potential mental health educators are enumerated.

California State Department of Public Health: California's Health, November 1, 1956, Vol. 14, No. 9, pp. 65-72.

In this article, Dr. Nyswander selects and discusses two principles in problem-solving. The first is that there are two major processes at work; one that is concerned in the task at hand; the other a process which is dependent on the dynamic impacts of personality needs of the members present. The second principle is this: The perceptions of those who are to be taught furnish important data to be used in program planning. She goes on to discuss other principles important to successful mental health education.

Psychiatric Research and the Assessment of Change, formulated by the Committee on Research, Group for the Advancement of Psychiatry, Vol. VI, Report No. 63, November 1966, pp. 357-471.

This report is an effort to clarify the opportunities and difficulties created from the encounter of new and more sophisticated trends in both psychiatry and its range of sister disciplines.

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